

**Cabinet for Health and Family Services
Office of Health Policy
Secretary's Advisory Committee on Health Care Transparency
Tuesday, January 19, 2010
1:00 PM – 3 PM
Public Health Auditorium – Conference Suite B**

Agenda

- I. Welcome and Opening Remarks
- II. Approval of Minutes (July 21, 2009)
- III. Regulation 900 KAR 7:030 – Data reporting by Health Care Providers
- IV. Reports required by statute that have been filed with LRC
- V. Non-compliant hospital report
- VI. Report on the status of the 28 Ambulatory Surgery Centers that need to submit data
- VII. Presentation on MONAHRQ
- VIII. Update on implementation of data collection services by KHA
- IX. Adjourn

**SECRETARY'S ADVISORY COMMITTEE ON HEALTHCARE
TRANSPARENCY MEETING**

**July 21, 2009
1:00 p.m.**

PRESENT:

Carrie Banahan
Office of Health Policy

D. Kurt Adams
Kentucky Chiropractic
Society

Sarah Chasteen
Kentucky Medical
Association

Marie Cull
Cull, Hayden, and Vance

Bill Doll
Jackson, Kelly PLLC

Charles Kendell (on behalf
of Dr. William Hacker)
Department for Public
Health

Al Perkins(on behalf of
Sharon Clark)
Department of Insurance

Chuck Warnick
Kentucky Hospital
Association

Ben Yandell
Norton Health Care

ABSENT:

Sharon Clark
Department of Insurance

Victor Cooper, DC
Cooper Chiropractic Center

Dr. William Hacker
Department for Public
Health

Betsy Johnson
Department for Medicaid
Services

Dr. John Lewis
Health Care Excel

Melanie Shrader
Kentucky Association of
Health Plans

Marty White
Kentucky Medical Association

STAFF:

Cabinet for Health and Family Services, Office of Health Policy
Allison Martinez Sheena Lewis
Beth Morris Chandra Venettozzi

CALL TO ORDER

Carrie Banahan called the meeting to order in the CHFS Auditorium, Suite C, located in the Health Services building.

APPROVAL OF MINUTES

The minutes from the April 28, 2009, meeting were approved as distributed.

STATUS OF DATA REPORTING REGULATION

The data reporting regulation has been filed. There were no comments received. It was heard by the ARRS Committee on July 14 and passed out of the committee. It will be referred to the Health and Welfare Committee on August 12 and should become effective on that date.

DISCUSS DRAFT EMERGENCY DEPARTMENT REPORT

Chandra Venettozzi presented a series of reports in response to specific questions from the group. The first report in the series was related to court or law enforcement admission types and their diagnosis. Payor source information on those admission types was requested for the next meeting. Chandra's second report focused on Cumberland County Hospital and where the patients treated in an emergency department in Cumberland County reside and their diagnosis.

Chandra then presented the report based on Emergency Department data that had been received for a 12 month period. The Data Advisory Subcommittee was presented with this report prior to the meeting and their changes have been incorporated into the report. An in depth discussion regarding the report followed. Ben stated his concern regarding the layout of the report and the possibility of the reader losing their place. Charlie Kendell suggested including the rates for other states and national rates for comparison. Allison Martinez suggested calculating the suicide and self-inflicted injury by patient Area Development District numbers per 100,000 population. The ED data report should be posted on the internet prior to the next Data Advisory Subcommittee.

KHQA DRAFT MAPS FOR DISCUSSION

The Office of Health Policy (OHP) is part of the Kentuckiana Health Alliance. As a collaborative effort between providers, consumers, and insurers to improve quality and efficiency in health care, the OHP offered their assistance in creating maps that were distributed with the meeting packets. Anthem, Humana, and Passport provided data derived from their Healthcare Effectiveness Data Information Set (HEDIS) measures to the Kentuckiana Health Alliance. Carrie asked the group for their input on posting these maps on the Transparency website. Ben suggested adding the 50th percentile, as well as the 75th percentile to the maps. He also suggested adding pie charts along with the maps.

STATUS OF AMBULATORY FACILITY REPORTING

There has been at least one ambulatory facility that has been able to submit data since May. Several more are in the testing phase. There are still some facilities who are struggling with various issues

such as software problems. The facilities are moving forward but the progress is slow. The specialized medical technology services facilities and mobile health services facilities were not contacted until May. Chandra wanted to give the ambulatory facilities an opportunity to get up and running.

ADJOURN

The meeting was adjourned at 2:20 p.m.

HEALTHCARE IN KENTUCKY:
A Report of the
Operations and Activities of
The Cabinet for Health and Family Services
Related to Health Data Collection for
Hospital Inpatient Discharge and
Outpatient Services
July 1, 2008 – June 30, 2009

Cabinet for Health and Family Services
Office of Health Policy
September 2009

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Executive Summary

KRS 216.2929 requires “The Cabinet shall at least annually, on or before October 1, submit a report on the operation and activities of the cabinet under KRS 216.2920 to 216.2929 during the preceding fiscal year, including a copy of each study or report required or authorized under KRS 216.2920 to 216.2929 and any recommendations relating thereto.” The Office of Health Policy (OHP) within the Cabinet for Health and Family Services (CHFS) has been charged with ensuring compliance with KRS 216.2920 to 216.2929. Therefore, this report is submitted in compliance with this requirement.

Cabinet Secretary’s Advisory Committee (SAC)

Pursuant to KRS 216.2923, the Secretary of the Cabinet for Health and Family Services shall appoint and convene a permanent cabinet advisory committee. The committee shall advise the secretary on the collection, analysis, and distribution of consumer-oriented information related to the health care system, the cost of treatment and procedures, outcomes and quality indicators, and policies and regulations to implement the electronic collection and transmission of patient information (e-health) and other cost-saving patient record systems. The committee met three times during the previous year as follows:

1. December 8, 2008 - agenda items: Introduction of new members, overview of purpose of committee, emergency department data submissions, new Ambulatory Facilities will begin data submissions, current status of transparency initiatives (including prevention quality indicators, inpatient quality indicators, and hospital charge information), update from last data advisory subcommittee meeting, and open discussion with committee regarding future transparency initiatives.
2. February 2, 2009 - agenda items: Preview new Inpatient Quality Indicator website, responses to questions from previous meeting, emergency department data submissions update, report on non-compliant facilities, and status of new Ambulatory Facility data submissions.
3. April 28, 2009 - agenda items: Presentation of draft emergency department utilization report, status of data reporting for new Ambulatory Facilities, status of data reporting regulation, funding for future emergency department data collections, and status of Prevention Quality Indicator reports using 2007 data.

Health Services Data Advisory Subcommittee (DAS)

KRS 216.2923 also specifies that the cabinet advisory committee shall utilize the Health Services Data Advisory Committee as a subcommittee to advise the cabinet on technical matters, including a review of administrative regulations, proper interpretation of the data, and the most cost-efficient manner in which it should be published and disseminated to the public, state and local leaders in health policy, health facilities, and health-care providers. The committee met three times during the year as follows:

1. August 27, 2008 - agenda items: Introduction of Office of Health Policy Executive Director; report by Chuck Warnick with the Kentucky Hospital Association of 2008 1st quarter data collection activities; Methicillin Resistant Staphylococcus Aureus (MRSA) collaborative meeting overview; 902 KAR 19:020 Release of Public Data Sets for Health Care Discharge Data Regulation; presentation by Dr. Kevin Kavanagh with Kentucky Health Watch regarding adverse events in hospitals, value index for hospitals, and the healthcare transparency & patient advocacy conference; and subcommittee membership.
2. December 15, 2008 - agenda items: Proposed changes to 902 KAR 19:020 – Data reporting regulation, reporting for new Ambulatory Facilities, corrective action plans for facility non-compliance for 1st and 2nd quarter 2008, status of annual survey submission, and recommendations for reports/uses for new emergency department data.
3. March 19, 2009 - agenda items: Update on Secretary's Advisory Committee on Transparency, debut of new Inpatient Quality Indicator web site, 900 KAR 7:030 – Data reporting regulation, presentation of draft emergency department utilization report.

Health Care Information Center

KRS 216.2923 requires that the Cabinet publish and make available information on charges for health care services and the quality and outcomes of health care services. KRS 216.2929 also requires CHFS to make available on its web site information on charges for health care services at least annually in understandable language with sufficient explanation to allow consumers to draw meaningful comparisons between every hospital and ambulatory facility, differentiated by payor if relevant, and for other provider groups as relevant data becomes available.

In response to these requirements, a web site was developed by the Office of Health Policy with information on Inpatient Quality Indicators and Prevention Quality Indicators using measures from the Agency for Healthcare Research and Quality (AHRQ). The web site includes a link to hospital charge information provided by the Kentucky Hospital Association and a link to the U.S. Department for Health and Human Services' Hospital Compare web site for quality measure comparisons. It also contains links to the federal government's internet home for information and resources related to health care transparency and value-driven health care. Data about the Inpatient Quality Indicators, Prevention Quality Indicators, and hospital charge information are updated annually to include the most recent year's data available. The web page may be accessed at <http://chfs.ky.gov/ohp/healthdata/>.

Legislation

No legislative changes have occurred during the past year.

Administrative Regulations

KRS 216.2927 requires that the Cabinet for Health and Family Services shall make all aggregate data which does not allow disclosure of the identity of any individual patient available to the public. Persons requesting use of the data shall agree to abide by a public-use data agreement and by HIPPA privacy rules referenced in 45 C.F.R. Part 164. An amendment was required to 902 KAR 19:030 to incorporate by reference an updated public-use data agreement which contained only technical changes. During the 2008 data collection period, a new data-element, MS-DRG (Medicare Severity Diagnosis Related Group), was added. Therefore, the regulation also needed to be amended to include this data element in the public use data set. The Kentucky Hospital Association participated with the Office of Health Policy in drafting language for the amendment.

Response to Requests for Summary Data and Reports

The following list is representative of summaries and reports that have been requested and disseminated during fiscal year 2008-2009. Many of these summaries and reports were created in response to requests from researchers, policy makers, and the general public, while others were created at the request of other agencies within the Cabinet for Health and Family Services. The following summaries and reports were generated by the Office of Health Policy using the Kentucky Inpatient Discharge data and the Outpatient Services data (the requesting party is listed in parentheses).

1. Inpatient Hospitalization days by facility and payor type of Medicaid, Medicare, or other; 2008 Annual Hospital Utilization and Services Report (B. Morris, Office of Health Policy, CHFS)
2. Inpatient Hospital leading twenty-five DRGs by facility Area Development District, 2008 Annual Hospital Utilization Services Report (B. Morris, Office of Health Policy, CHFS)
3. Inpatient Hospital facility activity by quarter, by facility Area Development District, and by patient residency, gender, age group, admission type, length of stay, and primary payor, 2008 Annual Hospital Utilization and Services Report (B. Morris, Office of Health Policy, CHFS)
4. Inpatient Hospital leading twenty-five MS-DRGs by facility Area Development District, 2008 Annual Hospital Utilization Services Report (B. Morris, Office of Health Policy, CHFS)
5. Emergency Department Utilization by facility and payor type of Medicaid, Medicare, or other; 2008 Annual Hospital Utilization and Services Report (B. Morris, Office of Health Policy, CHFS)
6. Emergency Department facility activity by facility Area Development District, by quarter and by patient residency, gender, age group, type of service, month of service, and primary payor, 2008 Annual Hospital Utilization and Services Report (B. Morris, Office of Health Policy, CHFS)
7. Emergency Department leading twenty-five principal diagnoses by facility Area Development District, 2008 Annual Hospital Utilization Services Report (B. Morris, Office of Health Policy, CHFS)
8. Number of Suicide and Self Inflicted Injury Inpatient Hospital Discharges by Gender – 2005 through September, 30 2008. (A. Wilburn, Department of Public Health, CHFS)

9. Psychiatric Diagnosis Inpatient Hospitalizations by Facility, County of Residence, and Principal Diagnosis 2004 to 2007. (B. Burns, CHFS)
10. Heart Disease Diagnosis Inpatient Hospitalizations by year, gender, age group, and principal diagnosis group 2001 to 2007. (Dr. Benjamin Horne, Department of Biomedical Informatics, University of Utah)
11. Emergency Department and Observation Stay visits by Payor, January 2008 to June 2008. (B. Johnson, Department of Medicaid Services, CHFS)
12. Detailed Emergency Department and Observation Stay report from January 2008 to June 2008. (C. Banahan, Office of Health Policy, CHFS)
13. Inpatient procedures at northern Kentucky hospitals. (C. Banahan, Office of Health Policy, CHFS)
14. Psychiatric inpatient discharges over age 65 by payor, 2007. (C. Banahan, Office of Health Policy, CHFS)
15. Mammograms by county in 2007. (C. Banahan, Office of Health Policy, CHFS)
16. Inpatient discharges by payor by county for births and low-birth weight births during 2006. (D. Jacovitch, Cabinet for Health and Family Services)
17. Inpatient Hospitalizations as a result of Injury and Poisoning by Discharge Status, 2007. (Dr. Steven Spady)
18. Influenza and Pneumococcal Pneumonia Inpatient Hospitalizations by Admission Source and Age, 2007. (Dr. K. Humbaugh, Department for Public Health, CHFS)
19. Wenener's Granulomatosis Diagnosis Inpatient Hospitalizations by year, 2004 to 2007. (Dr. Frank Groves, School of Public Health and Information Sciences, University of Louisville)
20. Rate of Hip Fractures in 2007 per 1,000 women age 65 and over. (J Grider, Department for Public Health, CHFS)
21. Hernia Inpatient Hospitalizations, 2006 and 2007. (J. Brandon)
22. Inpatient hospitalizations and Total Billed Charges for Low birth Weight by Payor, 2006. (J. Robl, Department for Public Health, CHFS)
23. Inpatient hospitalizations by facility for malignant neoplasm, 2007. (M. Herrler, Wise Global Consulting)
24. Inpatient hospitalizations by facility for non-malignant neoplasm, 2007. (M. Herrler, Wise Global Consulting)
25. Inpatient Hospitalizations by Area Development District for STEMI, 2007. (S. Block, American Heart Association/American Stroke Association)
26. Average billed charges for a hospital visit in 2007. (S. Robeson, Department for Public Health, CHFS)
27. Asthma Hospitalizations for children age 0 to 17, 2000-2002, 2004-2006, 2005-2007. (P. Tennen, Kentucky Youth Advocates)
28. Asthma Hospitalizations for children age 0 to 4, 2007. (T. Jewell, Department for Public Health, CHFS)
29. Inpatient Hospitalizations for non-fatal injuries to children age 15 or less. (T. Jewell, Department for Public Health, CHFS)
30. Inpatient Hospitalizations due to excessive heat and cold, 2006 and 2007. (W. Gunnels, Senator Bernie Sanders Office)
31. COPD Hospitalizations by County vs. Gender, 2006 – 2007 Hospital Discharge Data (C. Buckley, Public Health)

32. COPD Hospitalization Charge Data by Gender, 2006 – 2007 Hospital Discharge Data (C. Buckley, Public Health)
33. COPD Hospitalizations by Age Groups vs. Gender, 2006 – 2007 Hospital Discharge Data (C. Buckley, Public Health)
34. Asthma Hospitalization Rates by ADD, 2006 – 2007 Hospital Discharge Data (K. Nunn, Public Health)
35. Asthma Hospitalization Rates by ADD vs. Age Groups, 2006 – 2007 Hospital Discharge Data (K. Nunn, Public Health)
36. Asthma Hospitalization Rates by Counties, 2006 – 2007 Hospital Discharge Data (K. Nunn, Public Health)
37. Asthma Hospitalization Rates by Counties vs. Age Groups, 2006 – 2007 Hospital Discharge Data (K. Nunn, Public Health)
38. COPD Hospitalization Rates by County, 2006 - 2008 Hospital Discharge Data (K. Nunn, Public Health)
39. COPD Hospitalization Rates by County vs. Age Groups, 2007 Hospital Discharge Data (K. Nunn, Public Health)
40. COPD Hospitalization Rates by Age Groups, 2007 Hospital Discharge Data (K. Nunn, Public Health)
41. Blastomycosis Hospitalizations, 2005 – 2008 Hospital Discharge Data (E. Lutterloh, Public Health)
42. Sunburn Related Hospitalizations, 2008 Inpatient and Outpatient Discharge Data (B. Fisher, Communications)
43. Cardiac Catheterizations, Adults 18 and Older, 2008 Inpatient Discharge Data (A. Kirsch)
44. Cardiac Catheterizations, Adults 18 and Older, 2008 Outpatient Discharge Data (A. Kirsch)
45. Cardiovascular Disease Hospitalizations by County with Charge Data, 2007 – 2008 Hospital Discharge Data (B. Bobo, Public Health)
46. Heart Disease Hospitalizations by County with Charge Data, 2007 – 2008 Hospital Discharge Data (B. Bobo, Public Health)
47. Stroke Hospitalizations by County with Charge Data, 2007 – 2008 Hospital Discharge Data (B. Bobo, Public Health)
48. Flu Related Discharge Data, 2005 – 2008 Hospital Discharge Data (E. Lutterloh, Public Health)
49. Pelvic Inflammatory Disease Hospitalizations by Year and Quarter, with Total Charges and Patient Days, 2005 – 2008 Hospital Discharge Data (S. White, Public Health)
50. Juvenile Hospitalizations with Charge Data, 2007 – 2008 Hospital Discharge Data (C. Banahan, Office of Health Policy)
51. Catheterizations or CABGs by Facility, Patient Origin, 2007 Hospital Discharge Data (C. Banahan, Office of Health Policy)
52. Average Length of Stay (ALOS) for Hospitalizations by DRG, 2007 – 2008 Hospital Discharge Data (C. Banahan, Office of Health Policy)
53. Hospitalizations by DRG with Length of Stay Greater than ALOS, by Age Groups, 2007 – 2008 Hospital Discharge Data (C. Banahan, Office of Health Policy)

Public Use Data Sets

The Office of Health Policy creates public use data sets for each calendar year for inpatient discharges and for outpatient services (ambulatory surgery and mammograms), which are available for purchase by interested parties for \$1,500 each. Complete or partial data sets are provided to qualified researchers or other state agencies free of charge. Both the inpatient discharge data set and the outpatient services data set are also provided to the Healthcare Cost and Utilization Project (H-CUP), a nationwide health data collection and analysis effort sponsored by the Agency for Healthcare Research and Quality (AHRQ). Inpatient discharge data are included in H-Cup's Nationwide Inpatient Sample (NIS), together with similar data from thirty-seven other H-CUP partner states. Data from these state inpatient databases are also extracted and included in H-CUP's Kids' Inpatient Database (KID). As part of this project, Kentucky inpatient data is included in H-CUPnet, an interactive, web-accessible service which enables public access and comparison of H-CUP state partner data. Kentucky is also one of 27 state contributors of outpatient services (ambulatory surgery) data to H-CUP's State Ambulatory Surgery Data base.

Prior to receiving a public use data set, an Agreement for Use of Kentucky Health Claims Data Agreement must be signed. This agreement was modeled after a similar document used by the H-CUP project and has been approved by the Health Services Data Advisory Committee. This agreement prohibits the recipients from selling raw or summary data and tasks the recipient with maintaining the confidentiality of the data.

During this reporting period, the Office of Health Policy received \$25,500 from the sale of Public Use Data Sets.

The following list of Public Use Data Set users illustrates the diversity of application of Kentucky hospital discharge data and outpatient services data.

1. Inpatient discharge data set, 2006, 2007, 2008, (B. Kimball and W. Mark Twilla, Cabell Huntington Hospital)
2. Inpatient discharge data set, 2007 (D. Baker, Aspen Healthcare Metrics)
3. Eleven sets of Kentucky's public use inpatient data and outpatient services files were also purchased for various activities through H-CUP Project's Central Distributor.

HEALTHCARE IN KENTUCKY:

**The Cabinet for Health and Family Services
Biennial Report on Health Care Transparency**

July 1, 2007 – June 30, 2009

**Cabinet for Health and Family Services
Office of Health Policy
September 2009**

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Executive Summary

KRS 216.2929 requires “The Cabinet shall at least biennially, no later than October 1 of each odd-numbered year, report on matters pertaining to comparative health-care charges, quality, and outcomes, the effectiveness of its activities relating to educating consumers and containing health-care costs, and recommendations regarding its data collection and dissemination activities.” The Office of Health Policy (OHP) within the Cabinet for Health and Family Services (CHFS) has been charged with ensuring compliance with KRS 216.2920 to 216.2929. Therefore, this report is submitted in compliance with this requirement.

Health Care Information Center (Also referred to as the “Transparency” Web Site)

KRS 216.2923 requires that the Cabinet publish and make available information on charges for health care services and the quality and outcomes of health care services. KRS 216.2929 also requires CHFS to make available on its Web site information on charges for health care services at least annually in understandable language with sufficient explanation to allow consumers to draw meaningful comparisons between every hospital and ambulatory facility, differentiated by payor if relevant, and for other provider groups as relevant data becomes available.

In response to these requirements, a web site was developed by the Office of Health Policy (OHP) that provides information regarding Inpatient Quality Indicators and Prevention Quality Indicators using measures from the Agency for Healthcare Research and Quality (AHRQ). The web page may be accessed at <http://chfs.ky.gov/ohp/healthdata/>.

Charges for Health Care Services

The OHP web site includes a link to hospital charge information provided by the Kentucky Hospital Association. Data is provided based on Medicare Severity-Diagnosis Related Group (MS-DRG) for years 2006, 2007, and 2008. Results are displayed by hospital and provide number of discharges, median charges, 10th percentile charges, 90th percentile charges, average length of stay, and average age of the patient. Hospitals with less than 20 discharges for the specified MS-DRG are excluded as the sample size is considered too small to represent statistically reliable results.

Quality and outcomes of Health Care Services

The OHP web site includes information about quality and outcomes via Inpatient Quality Indicators and a link to the U.S. department for Health and Human Services’ Hospital Compare web site.

Hospital Compare was created through the efforts of the Centers for Medicare and Medicaid Services (CMS) along with members of the Hospital Quality Alliance. Hospital Compare has quality measures on how often hospitals provide some of the recommended treatments to get the best results for most patients. The web site provides a tool to determine how well hospitals care for patients with certain medical conditions or surgical procedures, and include results from a survey completed by patients about the quality of care they received during a recent hospital stay. The information on the web site comes from hospitals that have agreed to submit quality information to CMS.

A search may be conducted by hospital name, within a certain distance of a zip code, city, state, or county. After entering search criteria, information about medical conditions includes: heart attack; heart failure; chronic lung disease; pneumonia; diabetes in adults; and chest pain; and information about surgical procedures including: heart and blood vessels; abdominal; bladder, kidney, and prostate; female reproductive; and neck, back, and extremities. Results of a search will display the following:

- General information about the hospital such as name, address, telephone number, type of hospital, and if emergency services are provided.
- (If available) - Hospital process of care measures, hospital outcome of care measures, and survey of patients' hospital experiences. Examples of process of care measures are: percent of heart attack patients given aspirin at arrival, percent of pneumonia patients given oxygenation assessment, percent of heart failure patients given smoking cessation advice/counseling. An example of outcome of care measures is Death Rate of Heart Attack Patients. Survey of patients' hospital experiences may include: percent of patients who reported that their nurses "always" communicated well, percent of patients who reported that their pain was "always" well controlled, or percent of patients who reported that their room and bathroom were "always" clean.
- The average Medicare Payment of the hospital for the specified diagnosis related group (DRG), and the number of Medicare Patients Treated.

Inpatient Quality Indicators were created using Inpatient Quality Indicator (IQI) software developed by the Agency for Health Care Research and Quality and the Department for Health and Human Services. IQIs provide a measure of quality for specific medical conditions and surgical procedures performed in a Kentucky hospital. The data used to develop the IQI reports are standardized administrative information routinely submitted by Kentucky hospitals to bill for services. To fairly report on the quality of inpatient care, the data are risk-adjusted to account for differences in patient acuity or severity levels for each facility. The site contains quality indicators related to inpatient mortality for medical conditions, inpatient mortality for surgical procedures, and utilization of procedures for which there are questions of overuse, under use, or misuse. *Inpatient mortality for medical conditions* including the following:

- Acute Myocardial Infarction (Heart Attack) Mortality Rate
- Congestive Heart Failure (CHF) Mortality Rate
- Acute Stroke Mortality Rate
- Gastrointestinal Hemorrhage (Bleeding in the Digestive Tract) Mortality Rate
- Hip Fracture Mortality Rate
- Pneumonia Mortality Rate

- Carotid Endarterectomy Mortality Rate
- Acute Myocardial Infarction, Without Transfer Cases (Heart Attack cases excluding transfer cases) Mortality Rate

Inpatient mortality for surgical procedures includes the following:

- Abdominal Aortic Aneurysm Repair Mortality Rate
- Coronary Artery Bypass Graft (CABG-Heart Surgery) Mortality Rate
- Craniotomy (Brain Surgery) Mortality Rate
- Laparoscopic Cholecystectomy (Gallbladder Surgery) Mortality Rate
- Percutaneous Transluminal Coronary Angioplasty (PTCA) Mortality Rate

Utilization of procedures for which there are questions of overuse, under use, or misuse include the following:

- Cesarean Delivery Rate
- Vaginal Birth After Cesarean Delivery Rate, Uncomplicated
- Incidental Appendectomy in the Elderly Rate
- Bilateral Cardiac Catheterization Rate
- Primary Cesarean Delivery Rate
- Vaginal Birth After Cesarean (VBAC) Delivery, All

Each mortality indicator report provides a description of the medical condition or surgical procedure, a link to the medical definition, a link to a technical definition, the national rate, and the state risk adjusted rate. The results display the name of every hospital performing at least 20 of the procedures with the total number of procedures and the number of cases where death occurred. The risk adjusted rate for each hospital is then compared to either the national rate or state rate (whichever was selected for comparison) and the hospital rate is displayed in red if it is significantly worse than the comparison rate, green if it is significantly better than the comparison rate, and black if it is comparable to the comparison rate.

Each utilization indicator report provides a description of the selected indicator, a link to the medical definition, a link to a technical definition, the national rate, and the state risk adjusted rate. The results display the name of every hospital performing at least 20 of the specified IQIs with the total number of procedures and the number of cases with the specified outcome. The results may also be displayed in a graph.

The Office of Health Policy web site now contains data for three federal fiscal years: October 1, 2005 to September 30, 2006; October 1, 2006 to September 30, 2007; and October 1, 2007 to September 30, 2008. An additional year's data is added annually when it becomes available.

Prevention Quality Indicators were created using Prevention Quality Indicator (PQI) software developed by the Agency for Health Care Research and Quality and the Department for Health and Human Services. PQIs are a set of measures that can be used to identify “ambulatory care sensitive conditions,” which are conditions for which good outpatient care can potentially prevent the need for hospitalization, complications, or more severe disease. The data used to develop the PQI reports are also standardized administrative information routinely submitted by

Kentucky hospitals to bill for their services, and are risk-adjusted to account for the difference in patient severity levels. PQIs are presented as a percentage rate of population over age 18 or as a percentage rate of total admissions for the specified condition. Overall, Acute, and Chronic composite indicators are also available.

PQIs presented as a percentage rate of population over age 18 are:

- Diabetes short-term complication admission rate
- Diabetes long-term complication admission rate
- Chronic obstructive pulmonary disease admission rate
- Hypertension admission rate
- Congestive heart failure admission rate
- Dehydration Admission rate
- Bacterial pneumonia admission rate
- Urinary tract infection admission rate
- Angina admission without procedure
- Uncontrolled diabetes admission rate
- Adult asthma admission rate
- Rate of lower – extremity amputation among patients with diabetes

PQIs presented as a percentage rate of total admissions for the specified conditions are:

- Perforated appendix admission rate
- Low Birth Weight

Results for each PQI are displayed on a Kentucky map with each county colored in red, yellow, or green. Green indicates an area with a risk-adjusted rate (considering a margin of error) that is lower than the national average for that indicator. Yellow indicates an area with a risk-adjusted rate (considering a margin of error) that is comparable to the national average. Red indicates an area with a risk-adjusted rate (considering a margin of error) that is above the national average. For Prevention Quality Indicators, lower rates usually represent better outpatient care which can potentially prevent the need for hospitalization.

The web site now contains data for three calendar years: 2006, 2007, and 2008. An additional year's data is added annually when it becomes available.

The effectiveness of activities relating to educating consumers and containing health-care costs

As indicated above, the OHP web site provides a wealth of health care information related to charges, services, and quality. This information is used by hospitals, consumers, researchers, health departments, other state agencies, and policy makers as an effective means of education and decision making. Information about incidence of disease and outcomes is used by these entities for education as well as decisions that can help contain health-care costs. Consumers use the Inpatient Quality Indicators to help determine the outcomes for specific providers and to determine the costs for specific diagnoses. Policy makers and health departments use the Prevention Quality Indicators in their research and decision making.

Recommendations regarding data collection

The Office of Health Policy would recommend one change to the Commonwealth's present data collection process. Currently, the statute prohibits the collection of individually identifying information regarding patients. Therefore, any analysis completed is based on the number services provided rather than the number of patients served. For comparison purposes in analysis, results are usually stated as a number per 100,000 population.

- For example, county A may have had 437 emergency department visits per 100,000 population and county B had 374 emergency department visits per 100,000 population. The analysis would indicate that residents in county A utilized services in an emergency department 14.37% less frequently than county B. However, without a patient identifier this statement may not be accurate because the number of patients actually seen in an emergency department is unknown.
- For discussion purposes, that county A actually had 325 emergency department patients per 100,000 population and county B had 330 emergency department patients per 100,000 population. In this instance, county B would have utilized services more than county A.

The current analysis is valuable, but accurate counts of patients served as opposed to visits provided would prove to be far more valuable.

Patient identifiers would also be extremely useful in tracking hospital re-admissions to analyze the reasons patients were re-admitted to the hospital. Currently this is not possible. OHP would not identify who the patient is, but would utilize an identifier to track the services received by patients.

OHP is considering the addition of Patient Safety Indictors (PSI) on its web site. PSIs are a set of indicators that include 27 measures providing information on hospital complications and adverse events following surgeries, procedures, and childbirth and serve as a tool to help health system leaders identify potential adverse events occurring during hospitalization.. The indicators were developed by the Agency for Healthcare Research and Quality after a comprehensive literature review, analysis of the ICD-9-CM codes, review by a clinical panel, implementation of risk adjustment, and empirical analyses.

Other Information available on the Office of Health Policy web site

A link to the federal government's internet home for information and resources related to health care transparency and value-driven health care is also provided.

The 2009 Kentucky Minority Health Status Report

Prepared by:
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September 2009

CREDIT AND ACKNOWLEDGEMENTS

The 2009 Kentucky Minority Health Status Report

September 2009

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Executive Summary

The 2009 Kentucky Minority Health Status Report was prepared in accordance with Kentucky Regulatory Statutes (KRS) 216.2929 Section 6, which states:

“The cabinet shall report at least biennially, no later than October 1 of each odd-numbered year, on the special health needs of the minority population in the Commonwealth as compared to the population in the Commonwealth as compared to the population at large. The report shall contain an overview of the health status of minority Kentuckians, shall identify the diseases and conditions experienced at disproportionate mortality and morbidity rates within the minority population, and shall make recommendations to meet the identified health needs of the minority population.”

The Office of Health Equity (OHE), Kentucky Department for Public Health, along with the Kentucky Office of Health Policy (OHP), Secretary of the Kentucky Cabinet for Health and Family Services, were responsible for preparing this report.

The OHE was established in September 2008 through funding support from the United States Department of Health and Human Services (DHHS), Office of Minority Health. The Office of Health Equity addresses health disparities among racial and ethnic minorities, low-income, and geographically isolated populations in the Commonwealth. The primary objectives of the Office are to increase awareness of health disparities; strengthen leadership at all levels for addressing health disparities; enhance patient-provider communication; improve cultural and linguistic competency in delivering health services; and improve coordination and utilization of research and outcome evaluations.

OHE reports directly to the Commissioner of the Kentucky Department for Public Health.

The Office of Health Policy (OHP) was created on July 15, 2005 to ensure coordinated, timely, efficient and cost effective health planning and policy research. The Office reports directly to the Secretary of the Cabinet for Health and Family Services.

The 2009 Minority Health Status Report highlights statistical data for health outcomes of minority populations in Kentucky. The key findings are listed below:

- Kentucky is becoming increasingly diverse. The rate of population increase is higher for communities of color. For example from 1990 to 2000, the Hispanic population grew by (172.6%), Native Hawaiian and Other Pacific Islanders grew by (76.1%), Asians grew by (75.1%), African Americans grew by (12.6%), and non-Hispanic whites grew by (6.8%).
- Kentucky’s Hispanic population is younger, on average, than other groups.

- Kentucky's Hispanic population, on average, has lower educational attainment. Only 59.1% of Hispanics 25 years or older in Kentucky complete high school or receive their GED compared to 74.3% of non-Hispanic whites and 73.2% of African Americans.
- African Americans are twice as likely to live in poverty (28.2) as non-Hispanic whites (14.6%) and Hispanic (25.0%) in Kentucky.
- More than 44% of African American children under 5 years of age live in poverty compared to 20.4% of non-Hispanic whites and 29.0% of Hispanics.
- In 2007, non-elderly Hispanics had the highest rates of being without health insurance coverage (39.4%) compared to non-Hispanics whites (15.2%) and African Americans (22.6%).
- More than 29,000 Kentuckians have limited English proficiency at the time of the 2000 Census, and this number has likely increased since then.
- Age-adjusted mortality rates per 100,000 were higher for African Americans (1051.8) and Appalachian residents (994.5) in Kentucky compared to non-Hispanic whites (899.0), Hispanics (710.6) and non-Appalachian residents (866.1).
- African Americans are more likely to die from heart disease (261.1/100,000) than non-Hispanic whites (235.1/100,000).
- The cancer mortality rate per 100,000 is higher among African Americans (242.8/100,000) than non-Hispanic whites (203.34/100,000).
- According to Kaiser Health Facts data for 2008 Kentucky African Americans had a higher rate of obesity and overweight at (73.7%) when compared to non-Hispanic whites (64.7%), and Hispanics (48.7%). This same difference exists at the national level as well.
- On average from 2003-2007, African Americans had an AIDS diagnosis rate per 100,000 that was approximately eight times higher than for non-Hispanic whites. Hispanics had an AIDS diagnosis rate five times higher than for Whites in Kentucky.
- Gonorrhea disproportionately impacts African Americans when comparing case rates. Of the 4,548 cases reported in 2008, 48% were African Americans, 22% non-Hispanic white, and 1% Hispanic.
- African American infants were approximately twice as likely as Asian infants to be born preterm during 2004-2006 (average).
- Hispanics had the highest rates of being without insurance coverage.

- Chronic obstructive pulmonary disease (COPD) is the most frequent cause of use of emergency department services for African Americans and Hispanic.
- Asthma and heart failure are the most frequent cause for use of inpatient hospital services by African Americans and Hispanics.

These are among many of the health disparities that exist for the minority populations in Kentucky. The gaps exemplify inadequate access to healthcare and substandard quality of healthcare.

According to the DHHS, Office of Minority Health, in 2006, U.S. businesses spent \$496 billion on health services and supplies. Kentucky spends 16.9% of its Gross State Product (GSP) on health care expenditures, higher than the national average of 13.3%. Eliminating health disparities in the state of Kentucky would reduce an economic burden on the state, specifically by decreasing hospital utilization and associated medical costs, and by reducing Medicaid costs. State funds allocated to prevention including minority health, workforce development, and cultural and linguistic competency would be good investments in curbing these expenditures. While Kentucky has many challenges regarding health disparities, it also has opportunities to be a model for other states through its comprehensive collaborative efforts.

Closing gaps in health outcomes and health care would enhance the quality of life for all Kentuckians. Moreover, the improvement of social conditions among its growing diverse populations, along with the enhancement of policies to sustain development of healthier communities, will promote a healthier Kentucky.

Background

Healthy People 2010, the framework of prevention for public health, identified overarching goals of eliminating health disparities and increasing the quality and years of life. OHE strives to complement these goals by engaging in activities that encourage achievement of these goals. OHE will utilize the social determinants of health, or an array of the critical influences that determine the health of individuals and community to address health disparities in the state of Kentucky. The figure below displays a pictorial diagram of the social determinants of health concept.

How do social determinants influence health?

Multiple models describing how social determinants influence health outcomes have been proposed.³⁰⁻⁴⁰ Although differences in the models exist, some fairly consistent elements and pathways have emerged. The model presented here contains many of these elements and pathways and focuses on the distribution of social determinants (see Figure 1.1). As the model shows, social determinants of health broadly include both societal conditions and psychosocial factors, such as opportunities for employment, access to health care, hopefulness, and freedom from racism. These determinants can affect individual and community health directly, through an independent influence or an interaction with other determinants, or indirectly, through their influence on health-promoting behaviors by, for example, determining whether a person has access to healthy food or a safe environment in which to exercise.

Policies and other interventions influence the availability and distribution of these social determinants to different social groups, including those defined by socioeconomic status, race/ethnicity, sexual orientation, sex, disability status, and geographic location. Principles of social justice influence these multiple interactions and the resulting health outcomes: inequitable distribution of social determinants contributes to health disparities and health inequity, whereas equitable distribution of social determinants contributes to health equity. Appreciation of how societal conditions, health behaviors, and access to health care affect health outcomes can increase understanding about what is needed to move toward health equity.

Figure 1.1: Pathways from Social Determinants to Health

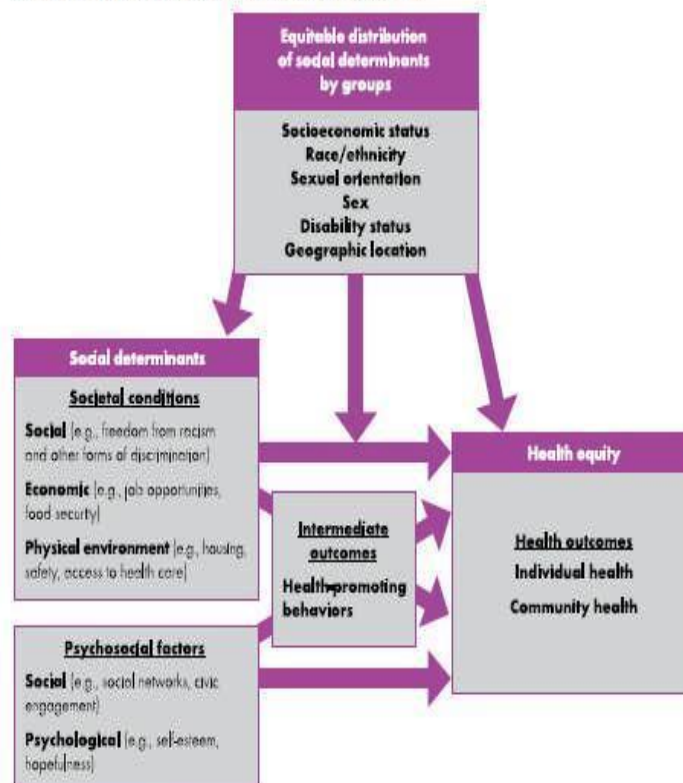


Figure adapted from Blue Cross and Blue Shield of Minnesota Foundation, http://www.bcbstmrfoundation.org/objects/Tier_4/mbc2_determinants_charts.pdf and Anderson et al, 2003.^{38,39}

What are health disparities?

Health disparities are the persistent gaps between the health status of minorities and non-minorities in the United States.

Two major factors for health disparities are:

1. Inadequate access to care

Barriers to care can result from economic, geographic, linguistic, cultural and health care financing issues. Even when minorities have similar levels of access to care, health insurance, and education, the quality and intensity of health care they receive are often poor. The same may also be true for impoverished and or rural populations.

2. Substandard quality of care

Lower quality care has many causes, including patient-provider miscommunication, provider discrimination, stereotyping, or prejudice. Quality of care is usually rated on the four measures of effectiveness, patient safety, timeliness, and patient centeredness.

What is health equity?

A basic principle of public health is that all people have a right to health. Differences in the incidence and prevalence of health conditions and health status between groups are commonly referred to as health disparities. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to the social determinants or conditions (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination) that support health. Health disparities are referred to as health inequities when they are the result of the systematic and unjust distribution of these critical conditions. Health equity, then, as understood in public health literature and practice, is when everyone has the opportunity to “attain their full health potential” and no one is “disadvantaged from achieving this potential because of their social position or other socially determined circumstance.”

The first project of OHE was to address racial/ethnic health disparities in infant mortality. Infant mortality is recognized as a critical indicator of overall health of a community and is frequently used by healthcare professionals, program planners, and decision makers to monitor the health status of a community or region. Infant mortality is defined as the number of infant deaths in a year for every 1000 live births. Infant mortality has been steadily decreasing in Kentucky and the United States. From 1992-2004 infant mortality declined 20% in the United

States and Kentucky. Although infant mortality has significantly declined, rates among different racial groups have not exhibited similar improvements. In the United States and Kentucky, African Americans are more than twice as likely to die within the first year of life than a white infant. African American births comprise 8.8% of births in Kentucky yet their infant mortality rate is more than twice that of Whites (10.9 per 1000 live births compared to 6.4 per 1000 live births). There are a variety of explanations for this drastic difference in infant mortality between different racial groups. Evidence suggest that low birth weight, preterm births, accessing prenatal care after the first trimester, engaging in risky behaviors, maternal age being less than 20 and less than high school education are factors associated with more adverse outcomes.

The Office of Health Equity partnered with the Louisville Center for Health Equity to identify the influences that lead to infant mortality by utilizing a social ecological perspective. The social ecological perspective or social determinants of health include addressing both societal conditions and psychosocial factors by which directly or indirectly impact health. Social determinants of health can be employment, access to health care, hopefulness, policies and interventions-from individual level factors to environmental factors. Through the use of this model we conducted focus groups with local community members of the Louisville, West End area, to determine the potential influences in that predominantly African American community, which contribute to the high rate of infant mortality in Kentucky.






The results of these focus groups are still being analyzed. However, insightful issues precipitated from the focus groups suggesting a need to improve housing, safety, and access to health care to encourage healthier pregnancy and birth outcomes for pregnant women in that area.

Future Direction

The 2009 Kentucky Minority Health Status Report provides a snapshot of the health status of minorities in the state given limited and low numbers of reported occurrences. However; there are glaring disparities for a significant number of preventable disease outcomes. More data is needed to fully understand the health of minority populations in Kentucky. This requires an expansion of funding and policies in order to adequately address these health disparities. Communities, policy-makers, public and private agencies, universities and individuals must come together to further expand research in the area of health disparities to move toward health equity. The Kentucky Office of Health Equity along with its partners are committed to working with partners to eliminate health disparities and improve the quality of life for all Kentuckians.

PART I

DEMOGRAPHICS

-  AGE AND POPULATION
-  EDUCATION
-  INCOME AND EMPLOYMENT
-  POVERTY
-  NATIVITY AND ENGLISH PROFICIENCY

Demographics

The boundaries of the Appalachian region do not correspond to Area Development District or other Kentucky regional designations larger than the county. As such, demographic data for the Appalachian region must be assembled from county-level data. The most current data available at this scale is from the 2000 Census. For this reason, to maintain comparability, all demographic data presented is from the 2000 Census.

Table 1.1 Kentucky Total Population by Race, Ethnicity and Geographic Region, 1990 and 2000

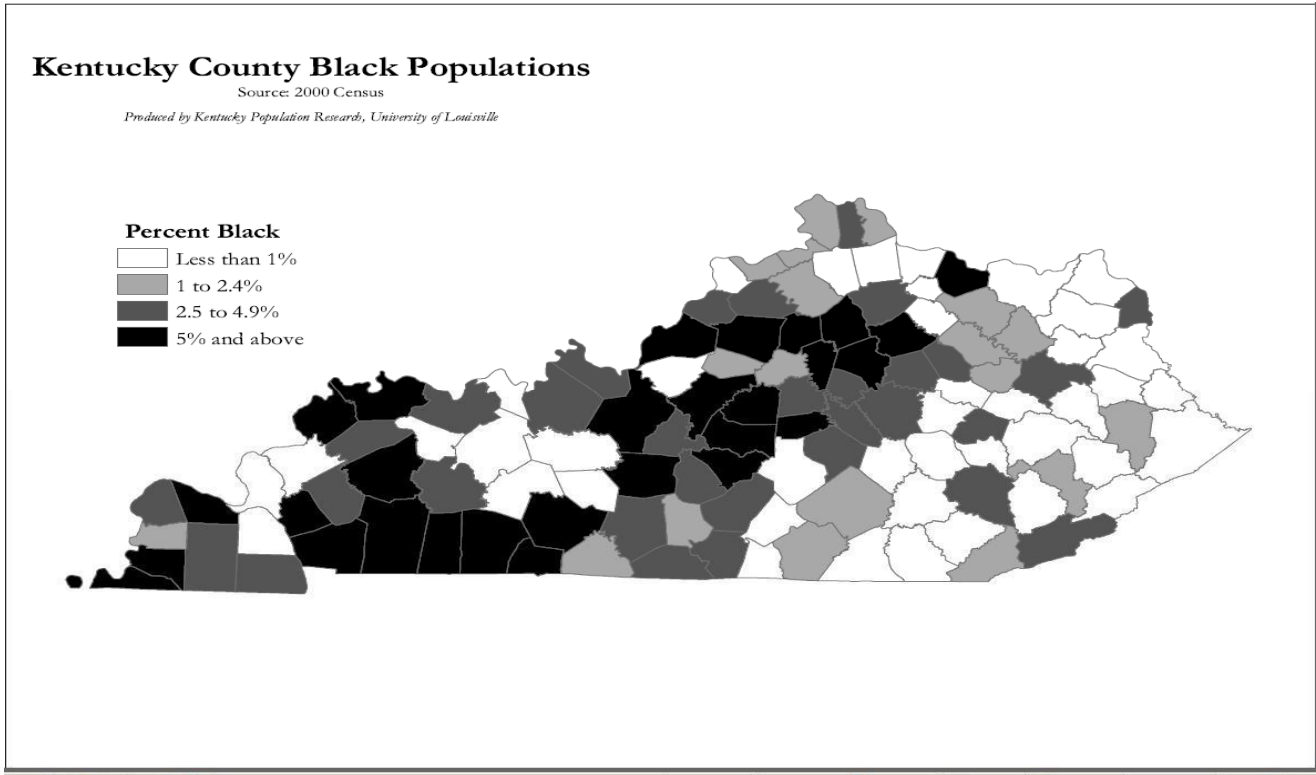
	1990 Census		2000 Census		Change	
	Number	Percent	Number	Percent	Number	Percent
Kentucky (Total)	3,685,296	100.0%	4,041,769	100.0%	15,030	9.7%
One Race	3,685,296	100.0%	3,999,326	98.9%	314,030	8.5%
White, non-Hispanic	3,378,022	91.7%	3,608,013	89.3%	229,991	6.8%
Black or African American	262,907	7.1%	295,994	7.3%	33,087	12.6%
American Indian and Alaska Native	5,769	0.2%	8,616	0.2%	2,847	49.3%
Asian	16,983	0.5%	29,744	0.7%	12,761	75.1%
Native Hawaiian and Other Pacific Islander	829	0.0%	1,460	0.0%	631	76.1%
Some Other Race	6,976	0.2%	22,623	0.6%	15,647	224.3%
Two or More Races	(X)	(X)	42,443	1.1%	(NA)	(NA)
Hispanic or Latino (of any race)	21,984	0.6%	59,939	1.5%	37,955	172.6%
Not Hispanic or Latino	3,663,312	99.4%	3,981,830	98.5%	318,518	8.7%
Appalachian Counties	1,088,416	29.5%	1,160,627	28.7%	72,211	6.6%
Non-Appalachian Counties	2,596,880	70.5%	2,881,142	71.3%	284,262	11.0%

Source: U.S. Census Bureau, Census 1990 Summary File 1 and Census 2000 Summary File 1 as analyzed by the Kentucky State Data Center

Between 1990 and 2000, Kentucky's total population grew by nearly 10%. Although the majority of the state's residents are non-Hispanic whites, the rate of population increase is higher for communities of color. This indicates that Kentucky is becoming increasingly diverse. While the methodology for population projections used in Kentucky does not address race or ethnicity, we expect that this trend will continue in the future.

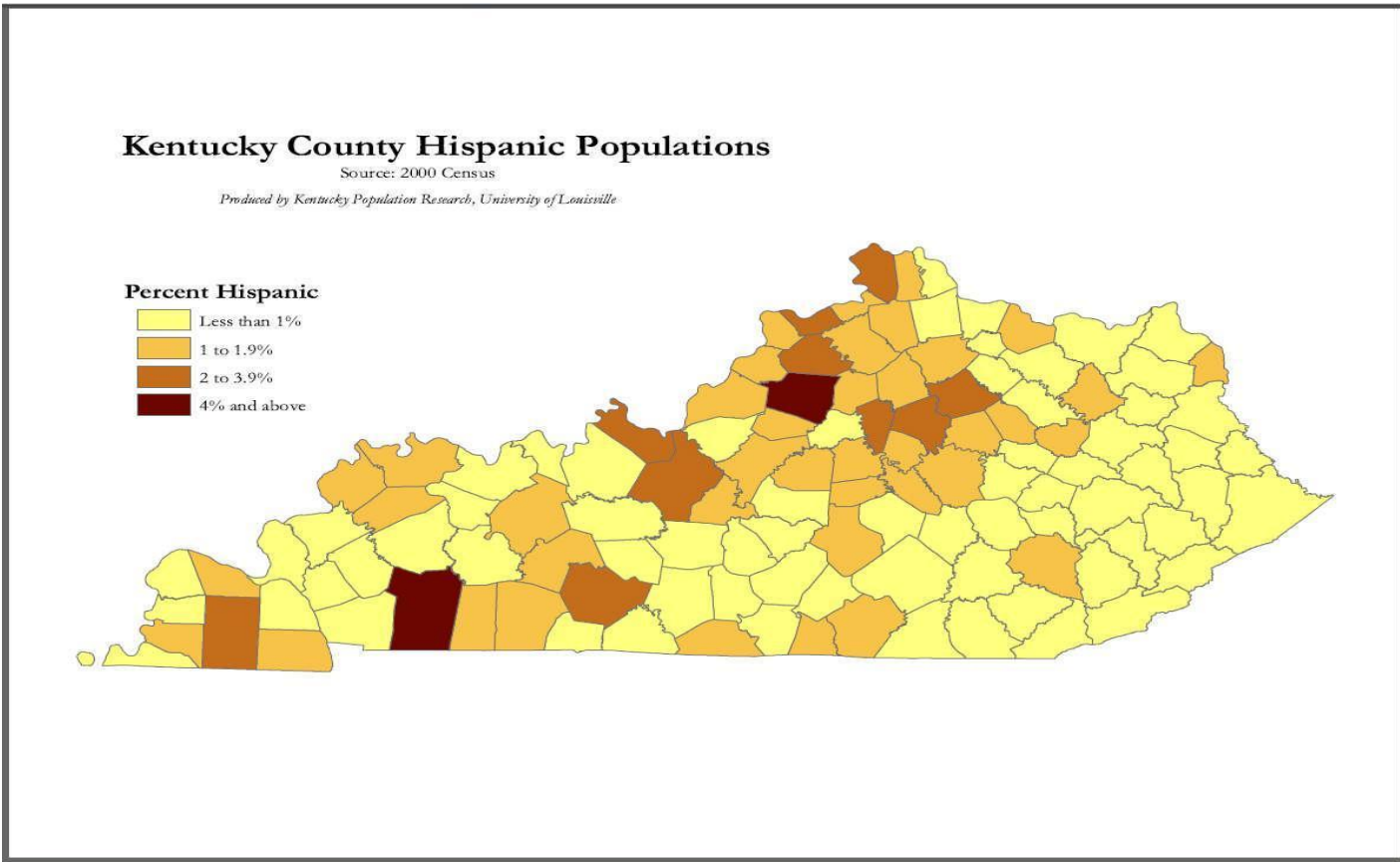
Despite the statewide trend towards increasing diversity, most people of color live in a few specific counties. This suggests that racial and ethnic segregation persists in Kentucky today.

Figure 1.1: Kentucky County Black Populations



Figure

1.2: Kentucky Hispanic Population



Age and Population

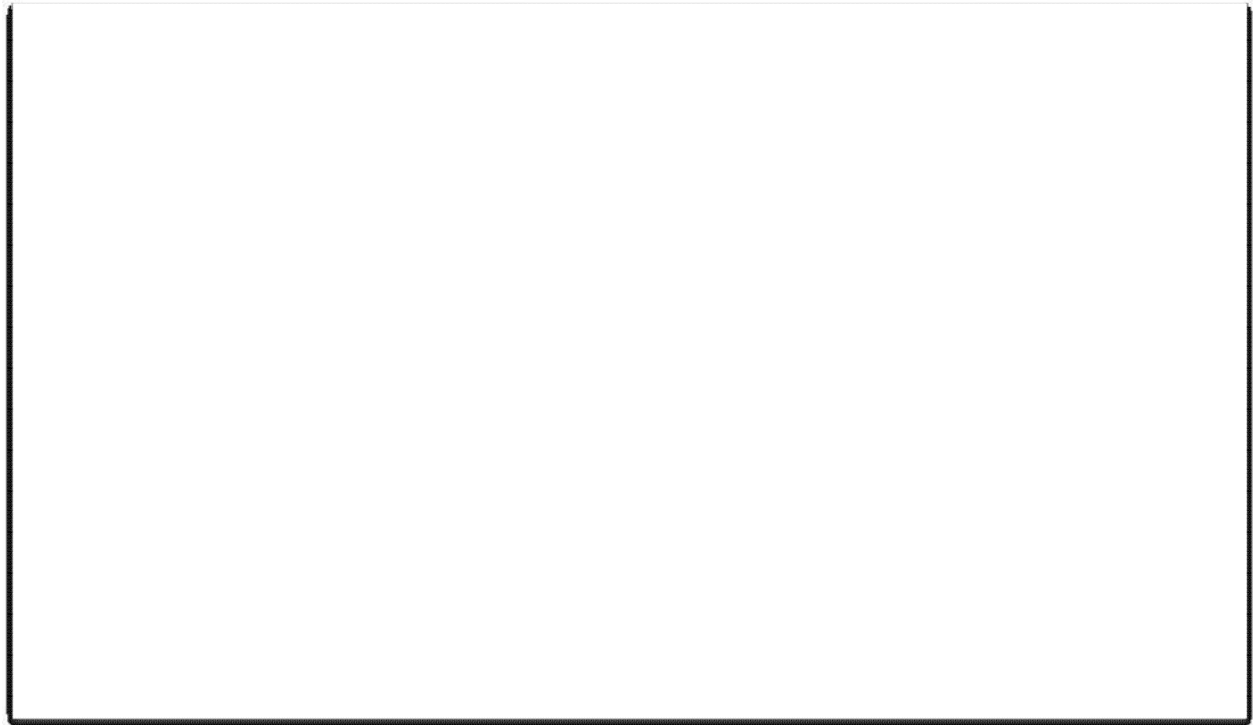
As illustrated in the first pyramid, Kentucky's total population is defined by the aging of the "baby boom" generation, with the largest age group being those who were aged 35-49 in 2000. Obviously, the baby boomers have continued to age since 2000 and now in their late 40s, 50s, and early 60s.

Looking at the pyramids for individual racial and ethnic groups, we see the dominant baby boom in the African American population, but also a greater proportion of young people coming up behind them.

Figure 1.3: Kentucky 2000 Population Estimates (Total, Black Alone, Asian Alone)



Figure 1.4: Kentucky 2000 Population Pyramids (Hispanic, White Alone)



Kentucky's Hispanic population is younger, on average, than other groups. Most Hispanics in Kentucky are working age or younger, with a comparatively small number of seniors. Rather than being defined by the baby boom, this pyramid tells the story of more recent immigration.

Education

Table 1.2: Educational Attainment by Race and Ethnicity, Population Aged 25 and Older, 2000

		State			
		Total	White, non-Hispanic	Black or African American	Hispanic (any race)
Total		2,646,397	2,404,049	170,321	28,131
Male		1,259,425	1,142,178	79,221	17,218
	Less than 9 th grade	200,519	142,685	5,578	4,585
	9 th to 12 th grade, no diploma	137,886	162,647	15,690	3,043
	High school graduate (or GED)	419,712	382,634	28,306	4,290
	Some college, no degree	225,542	201,856	17,720	2,625
	Associate degree	49,332	43,838	3,895	688
	Bachelor's degree	138,688	128,745	5,424	1,052
	Graduate or professional degree	87,746	79,773	2,608	935
Female		1,386,972	1,261,871	91,100	10,913
	Less than 9 th grade	203,868	143,732	6,703	1,876
	9 th to 12 th grade, no diploma	142,727	169,360	17,706	2,013
	High school graduate (or GED)	468,565	430,974	28,795	2,733
	Some college, no degree	264,628	236,032	22,319	2,057
	Associate degree	80,149	72,730	5,453	575
	Bachelor's degree	132,730	122,001	6,237	1,117
	Graduate or professional degree	94,305	87,042	3,887	542

Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

The proportion of the population to complete high school or receive their GED is comparable for non-Hispanic whites and African Americans in the state. In Kentucky, 74.3% of non-Hispanic whites and 73.2% of African Americans in Kentucky aged 25 and older have finished high school. The percent of individuals going on to college is likewise similar, with 40.4% of non-Hispanic whites and 39.7% of African Americans over 25 having attended at least some college. A disparity arises when it comes to college completion, although Kentucky African Americans attend college in similar numbers, they are less likely to graduate.

Of those who attended at least some college, 55.0% of non-Hispanic whites have completed a degree program (22.2% of all non-Hispanic whites over 25), while only 40.7% of African Americans receive degrees (16.1% of all African Americans over 25).

Hispanics trail both of these groups with only 59.1% high school completion and 34.1% college attendance. However, college-bound Hispanics seem to fare slightly better than African Americans. Of those who attend at least some college, 51.2% of Hispanics have a college degree (17.5% of all Hispanics over 25).

Figure 1.5: Educational Attainment by Race and Ethnicity, Population Aged 25 and Older, 2000



Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

The following map illustrates the profound regional variation in educational attainment in Kentucky. The percent of adults aged 25 and older who have completed high school or received their GED is markedly lower in the Appalachian region. This pattern of limited educational attainment impacts the ability of eastern Kentucky residents to find good-paying jobs, and ultimately to afford health care and preventive service

Figure 1.6: Percent of Kentucky Residents 25+ Completing High School 2000



Income and Employment

African American men are less likely to be in the workforce (meaning not employed and not seeking work) in Kentucky than non-Hispanic white or Hispanic men. Of those who are in the workforce, African American men were also more likely to be unemployed (12%) than non-Hispanic white (5%) or Hispanic men (8%).

People of color enlist in the military at a disproportionate rate relative to non-Hispanic whites. Five percent of all African American men and 9% of all Hispanic men in the workforce are in the armed forces, whereas only 1% of non-Hispanic white men in the workforce are in the armed forces.

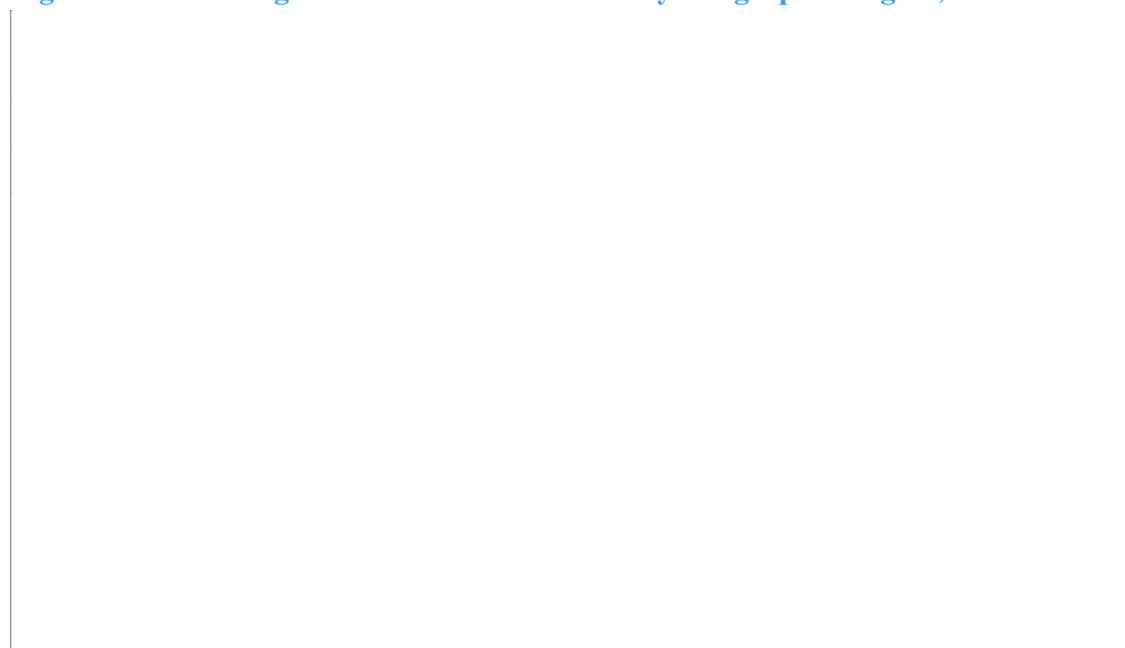
More than one-third of males aged 16-64 in Appalachian counties was not in the workforce, meaning they were not employed or seeking work. In non-Appalachian counties, only 20% of males in this age group are not in the workforce. See figure

Table 1.3: Persons Aged 16-64 in the Workforce by Sex by Race, Ethnicity and Geographic Region, 2000

		State				Region	
		Total	White, non- Hispanic	Black or African American	Hispanic (any race)	Appalachian Counties	Non- Appalachian Counties
Total		2,657,874	2,851,060	215,138	40,290	764,966	1,892,908
Male		1,319,896	1,368,661	102,492	25,273	379,322	940,574
	In labor force	1,000,673	934,751	61,884	19,128	245,670	755,003
	Armed forces	17,475	11,820	3,167	1,649	447	17,028
	Civilian	983,198	922,931	58,717	17,479	245,223	737,975
	Employed	926,194	875,399	51,159	15,948	225,008	701,186
	Unemployed	57,004	47,532	7,558	1,531	20,215	36,789
	Not in labor force	319,223	433,910	40,608	6,145	133,652	185,571
Female		1,337,978	1,482,399	112,646	15,017	385,644	952,334
	In labor force	866,222	801,080	66,833	7,963	208,906	657,316
	Armed forces	1,642	857	615	103	28	1,614
	Civilian	864,580	800,223	66,218	7,860	208,878	655,702
	Employed	814,094	758,227	58,936	7,012	192,725	621,369
	Unemployed	50,486	41,996	7,282	848	16,153	34,333
	Not in labor force	471,756	681,319	45,813	7,054	176,738	295,018

Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

Figure 1.7: Males Ages 16-64 in the Workforce by Geographic Region, 2000



Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

Figure 1.8: Males Ages 16-64 in the Workforce by Race and Ethnicity, 2000

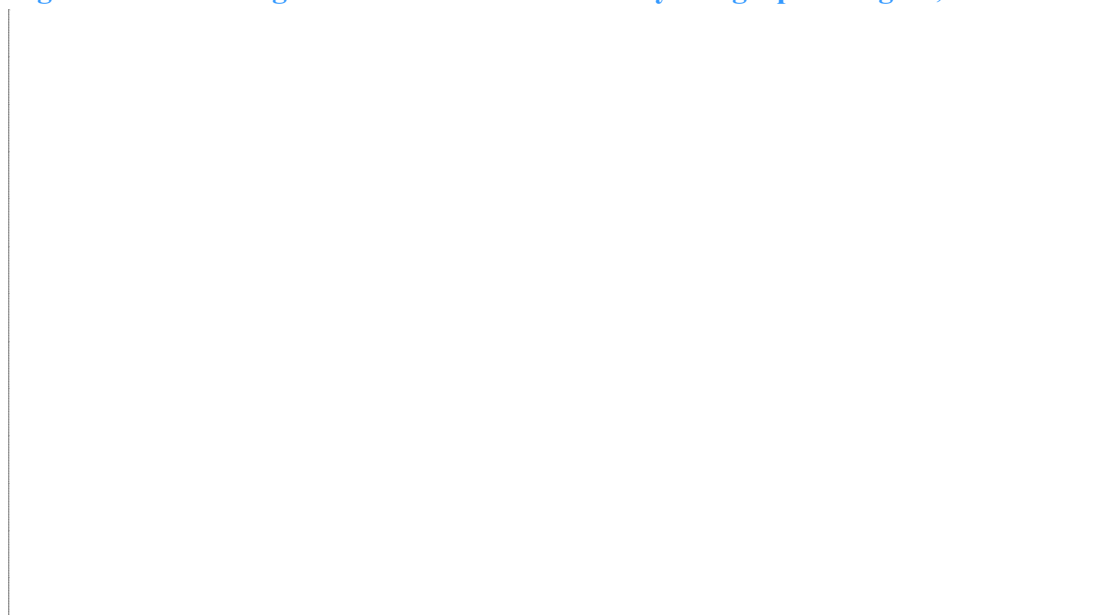


Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

African American men are less likely to be in the workforce (meaning not employed and not seeking work) in Kentucky than non-Hispanic white or Hispanic men. Of those who are in the workforce, African American men were also more likely to be unemployed (12%) than non-Hispanic white (5%) or Hispanic men (8%).

People of color enlist in the military at a disproportionate rate relative to non-Hispanic whites. Five percent of all African American men and 9% of all Hispanic men in the workforce are in the armed forces, whereas only 1% of non-Hispanic white men in the workforce are in the armed forces.

Figure 1.9: Males Ages 16-64 in the Workforce by Geographic Region, 2000



Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

More than one-third of males aged 16-64 in Appalachian counties was not in the workforce, meaning they were not employed or seeking work. In non-Appalachian counties, only 20% of males in this age group are not in the workforce.

Poverty

According to the 2000 Census, 24.4% of Kentuckians in Appalachian counties were living in poverty, compared to only 12.4% in non-Appalachian counties.

African Americans are twice as likely to live in poverty as non-Hispanic whites in Kentucky. Nearly one in four young children in Kentucky lives in poverty, but children of color are much more likely to be in poverty than non-Hispanic whites. More than 44% of African American children under 5 live in poverty.

On average, African American households earn \$10,000 less per year than their white counterparts and \$,5000 less than Hispanics. These economic disparities profoundly influence the health status of African American families in Kentucky.

Table 1.4: Income and Poverty Status by Race, and Ethnicity, 2000

	State			
	Total	White, non-Hispanic	Black or African American	Hispanic (any race)
Below Poverty Level	15.8%	14.6%	28.2%	25.0%
Children Under 5 Below Poverty Level	23.0%	20.4%	44.1%	29.0%
Children Under 17 Below Poverty Level	16.8%	15.4%	30.8%	25.6%
Median Household Income	\$33,672	\$34,665	\$24,278	\$29,541
Per Capita Income	\$18,093	\$18,629	\$13,235	\$11,962

Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

Of the 54 Appalachian counties in Kentucky, 38 have been classified as economically distressed by the Appalachian Regional Commission, placing them in the worst 10% of the nation's counties. Ten additional counties are designated as "at-risk," ranking between the worst 10% and 25% of the nation's counties.

Appalachian Region: Fifty-four counties in Kentucky have been designated as Appalachian by the Appalachian Regional Commission (www.arc.gov). The counties included in the Appalachian region are Adair, Bath, Bell, Boyd, Breathitt, Carter, Casey, Clark, Clay, Clinton, Cumberland, Edmonson, Elliott, Estill, Fleming, Floyd, Garrard, Green, Greenup, Harlan, Hart, Jackson, Johnson, Knott, Knox, Laurel, Lawrence, Lee, Leslie, Letcher, Lewis, Lincoln, McCreary, Madison, Magoffin, Martin, Menifee, Metcalfe, Monroe, Montgomery, Morgan, Nicholas, Owsley, Perry, Pike, Powell, Pulaski, Robertson, Rockcastle, Rowan, Russell, Wayne, Whitley, and Wolfe.

Note: Metcalfe, Nicholas and Robertson counties were added in October 2008.

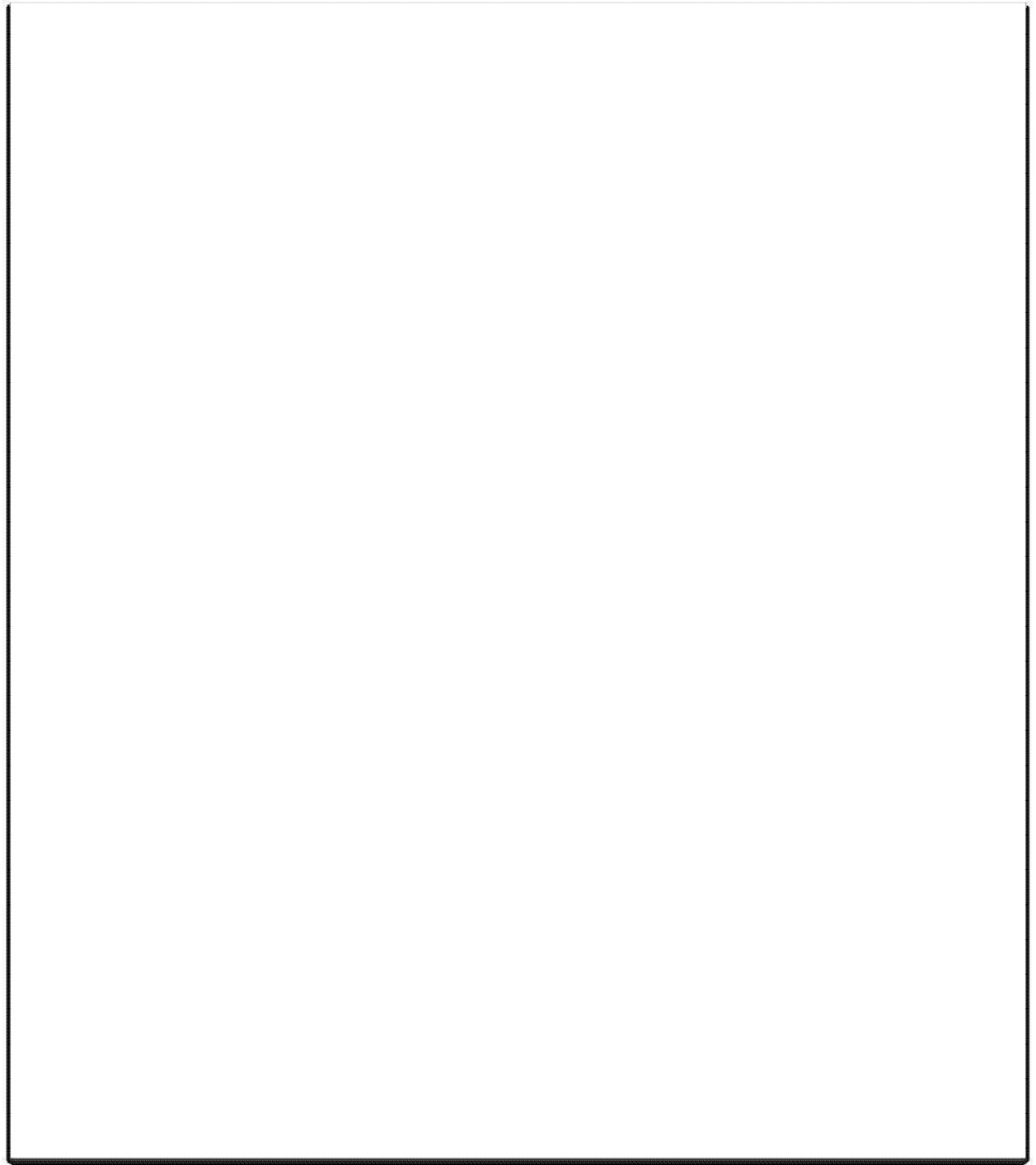


Figure 1.9: County Economic Status in Appalachia, Fiscal Year 2009

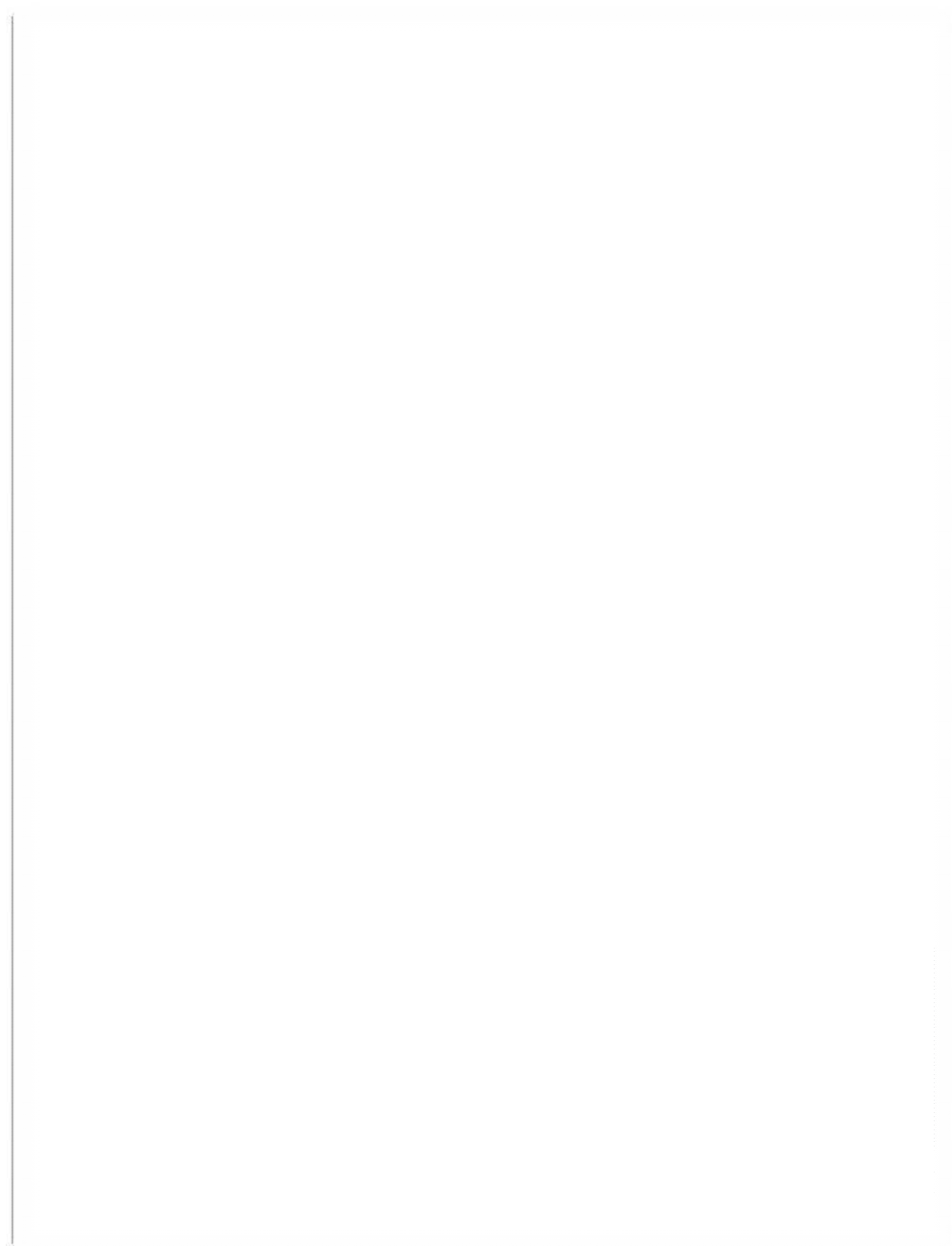


Figure 1.10: Economic Status Classification System, FY 2009

Nativity and Limited English Proficiency

Only 2% of Kentucky's population is foreign born (this excludes those who were born abroad to American parents). Of those individuals, approximately 1/3 have become naturalized citizens of the United States. Foreign-born Hispanics are less likely to naturalize than non-Hispanic whites or African Americans, suggesting that there are more barriers in the pathway to citizenship for some immigrants than others.

Table 1.5: Place of Birth and Citizenship, 2000

		State			
		Total	White, non-Hispanic	Black or African American	Hispanic (any race)
Total		4,041,769	3,610,112	293,915	56,414
Native Born		3,961,498	3,583,634	289,430	32,864
	Born in Kentucky	2,980,272	2,710,067	221,430	13,699
Foreign Born		80,271	26,478	4,485	23,550
	Naturalized Citizen	27,569	11,422	1,430	4,419
	Not a Citizen	52,702	15,056	3,055	19,131

Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

Table 1.6: Language Spoken in the Home by Ability to Speak English and Nativity, Ages 5 years and older, 2000





	Total	Native	Foreign Born
Total Population(Age 5 and Over)	3,776,230	3,697,798	78,432
Speak only English at home	3,627,757	3,610,343	17,414
Speak Spanish at home	70,061	47,942	22,119
Speak English “not well” or “not at all”	18,103	7,298	10,805
Speak other Indo-European languages at home	51,025	32,390	18,635
Speak English “not well” or “not at all”	5,935	3,363	2,572
Speak Asian or Pacific Island languages at home	21,031	4,807	16,224
Speak English “not well” or “not at all”	4,388	414	3,974
Speak other languages at home	6,356	2,316	4,040
Speak English “not well” or “not at all”	615	122	493

Source: U.S. Census Bureau, Census 2000 Summary File 3 as analyzed by the Kentucky State Data Center

About 4% of Kentuckians over the age of 5 speak a language other than English at home. More than 29,000 Kentuckians had limited English proficiency at the time of the 2000 Census, and this number has likely increased since then. Although the United States has no official language, it is difficult to obtain health care if one does not speak English fluently. This underscores the need for interpreter and translation services in the state.

PART II

HEALTH INDICATORS

-  ALL-CAUSE MORTALITY
-  CHRONIC DISEASE
-  CANCER
-  INFECTIOUS AND SEXUALLY
TRANSMITTED DISEASE
-  INJURY
-  MATERNAL AND CHILD HEALTH
-  ORAL HEALTH
-  ACCESS TO HEALTH CARE

All Causes Mortality

Table 2.1: All-Causes Mortality and Mortality Rates per 100,000 Population by Race, Ethnicity and Geographic Region, 2003-2007

		State				Region	
		Total	White, non- Hispanic	Black or African American	Hispanic (any race)	Appalachian Counties	Non- Appalachian Counties
Age-Adjusted Total Mortality Rate		903.4	899.0	1051.8	710.6	994.5	866.1
Crude Death Rate		942.8	979.7	804.4	321.3	1061.7	896.0
Age-Specific Crude Death Rates							
	0 to 4 years	167.3	151.0	269.6	252.1	184.0	161.3
	5 to 9 years	14.5	14.0	18.6	21.7	18.7	12.9
	10 to 14 years	20.3	20.2	20.7	21.3	27.0	17.7
	15 to 19 years	79.1	79.5	72.7	127.5	107.5	68.0
	20 to 24 years	113.5	111.7	130.1	136.8	149.8	99.7
	25 to 29 years	127.2	126.2	157.3	135.0	170.9	108.8
	30 to 34 years	149.0	149.1	176.6	152.7	205.4	127.1
	35 to 39 years	196.9	198.6	231.0	151.1	265.5	170.3
	40 to 44 years	291.2	288.8	378.1	224.8	378.1	258.6
	45 to 49 years	417.7	408.7	612.9	223.9	490.7	390.1
	50 to 54 years	592.8	573.0	942.2	480.3	693.7	553.2
	55 to 59 years	864.6	850.5	1,221.6	781.7	1,019.9	800.4
	60 to 64 years	1,380.1	1,362.6	1,941.6	938.6	1,598.9	1,286.0
	65 to 69 years	2,123.9	2,102.1	2,742.6	1,986.4	2,399.9	1,998.2
	70 to 74 years	3,208.8	3,185.3	3,992.6	2,433.5	3,508.3	3,076.0
	75 to 79 years	4,867.1	4,840.9	5,802.7	3,657.7	5,237.6	4,714.6
	80 to 84 years	7,485.5	7,501.2	7,667.5	5,631.6	7,859.8	7,337.0
	85 years and older	14,827.4	14,968.5	13,424.8	10,796.5	15,003.6	14,760.1

Source: Kentucky Vital Statistics Death Certificate Data (2003-2007) as analyzed by the Kentucky State Data Center

Age-adjusted mortality rates for African Americans in Kentucky are markedly higher than for non-Hispanic whites or Hispanics. The crude age-specific mortality rates indicate that this increased risk of death continues throughout the lifespan, but is most pronounced in early childhood and middle age.

Though Hispanics have a lower overall mortality rate than non-Hispanics, early childhood mortality is elevated for this population indicating a potential target for intervention. (Note: the crude death rate for Hispanics is considerably lower than for other racial and ethnic groups due to the relatively young population in Kentucky). While the age-adjusted rate is still lower than

for other groups it is more representative. Geographic disparities are also evident in the age-adjusted mortality rates, with considerably higher death rates observed in Appalachian counties as opposed to non-Appalachian counties.

Heart Disease

Table 2.2: Angina and Coronary Heart Disease in KY

Race	% Reporting Yes to Angina or Coronary Heart Disease
White	6.0% (5.2-6.8)
Black	4.5% (1.7-7.3)
Hispanic	2.4% (0-4.8)
Other	10.8% (2-19.8)

Source: 2008 Behavioral Risk Factor Surveillance Survey Data, Centers for Disease Control and Prevention

Table 2.3: Myocardial Infarction in KY (BRFSS, 2008)

Race	% Reporting Yes to Myocardial Infarction
White	5.4% (4.9-6.0)
Black	5.4% (2.1-8.7)
Hispanic	4.0% (0.4-7.6)
Other	5.2% (0.3-10.0)
Multiracial	6.3% (0.8-11.7)

Source: 2008 Behavioral Risk Factor Surveillance Survey Data, Centers for Disease Control and Prevention

Table 2.4: Heart Disease Mortality Rates per 100,000 by Race

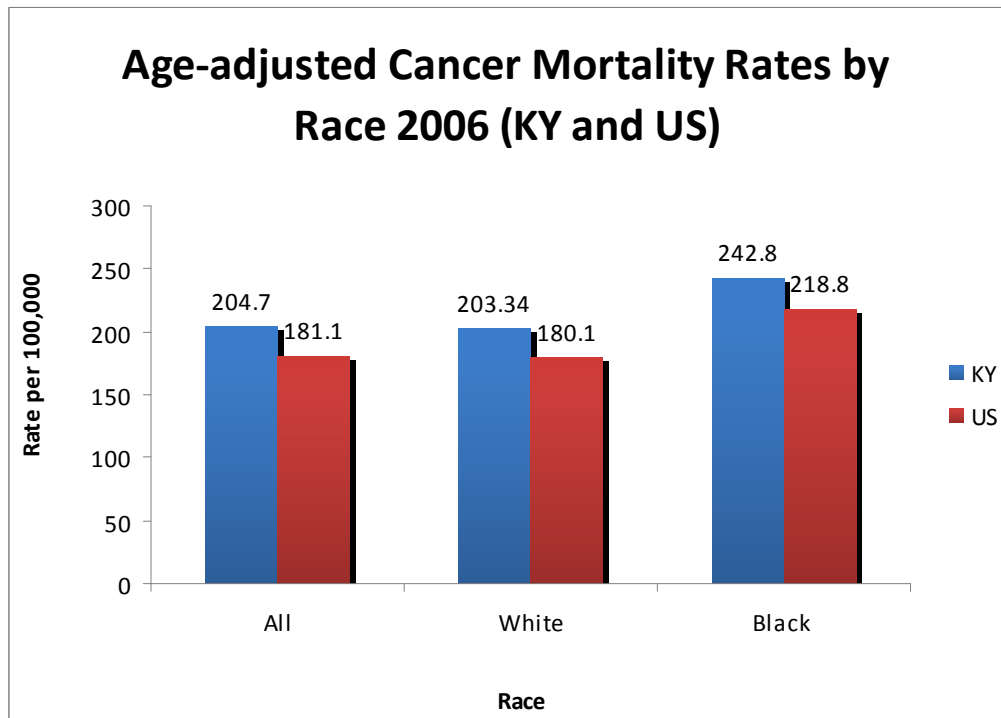
Race	KY	US
White	235.1	197.0
Black	261.1	257.9
Other	87.8	114.0

Source: 2006 Kaiser Family Foundation Data

The rate of heart disease deaths is higher in KY than the national rate for all races.

Cancer

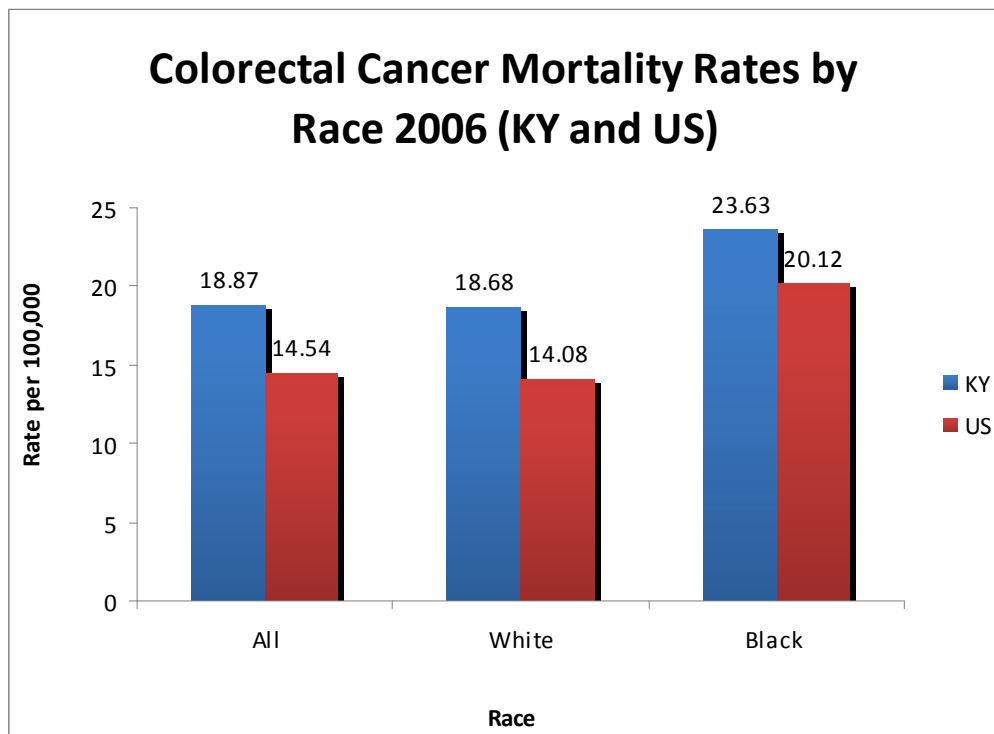
Figure: 2.1: Age Adjusted Cancer Mortality Rates by Race 2006 (KY and US)



The graph above illustrates the age-adjusted mortality rates for all cancers by race in Kentucky and the United States. According to the Kentucky Cancer Registry and the National Center for Health Statistics (NCHS), the cancer mortality rate is higher among blacks than whites in both Kentucky and the US.

Colorectal Cancer

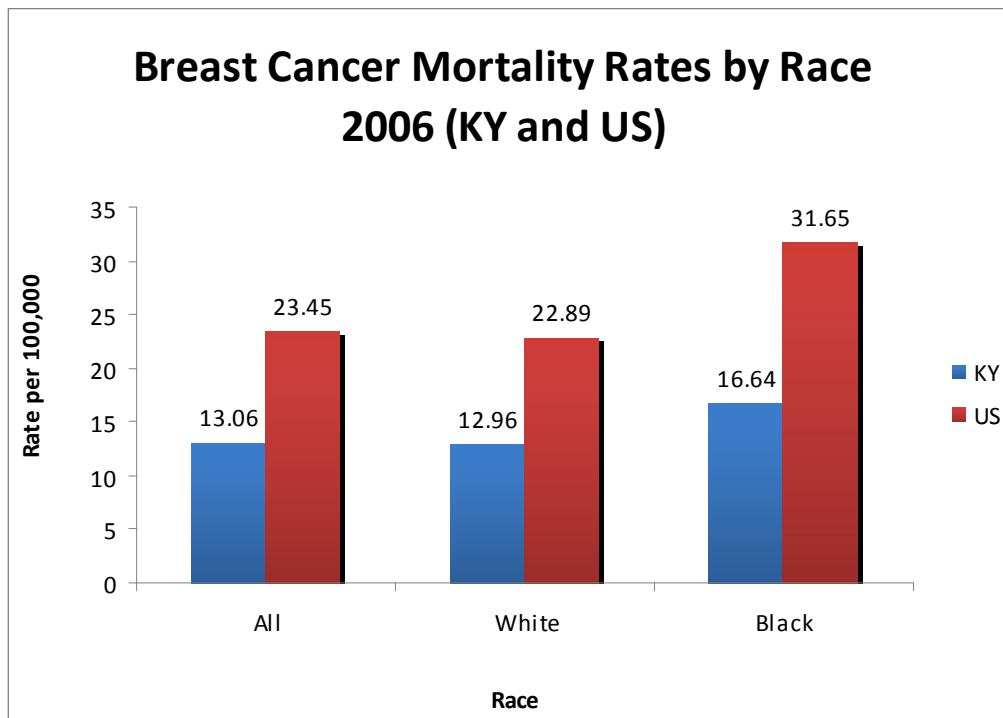
Figure 2.2: Colorectal Cancer Mortality Rates by Race 2006 (KY and US)



The graph above illustrates the age-adjusted mortality rates for colorectal cancer by race in Kentucky and the United States. According to the Kentucky Cancer Registry and the National Center for Health Statistics (NCHS), the colorectal cancer mortality rate is higher among blacks than whites in both Kentucky and the US.

Breast Cancer

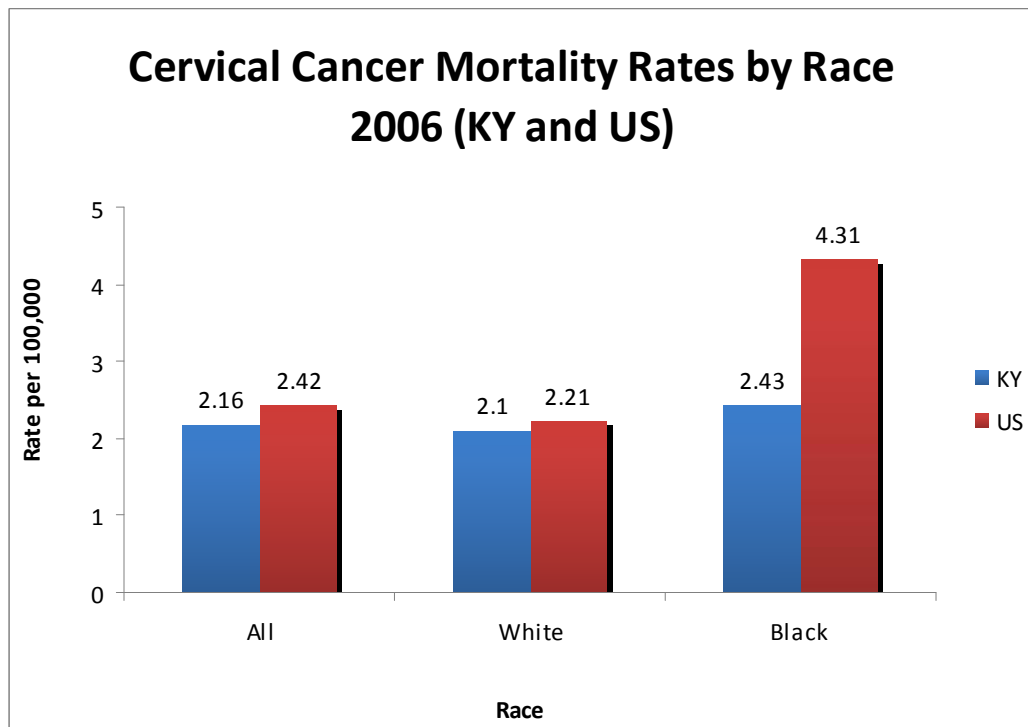
Figure 2.3: Breast Cancer Mortality Rates by Race 2006 (KY and US)



The graph above illustrates the age-adjusted mortality rates for breast cancer by race in Kentucky and the United States. According to the Kentucky Cancer Registry and the National Center for Health Statistics (NCHS), the breast cancer mortality rate is higher among blacks than whites in both Kentucky and the US.

Cervical Cancer

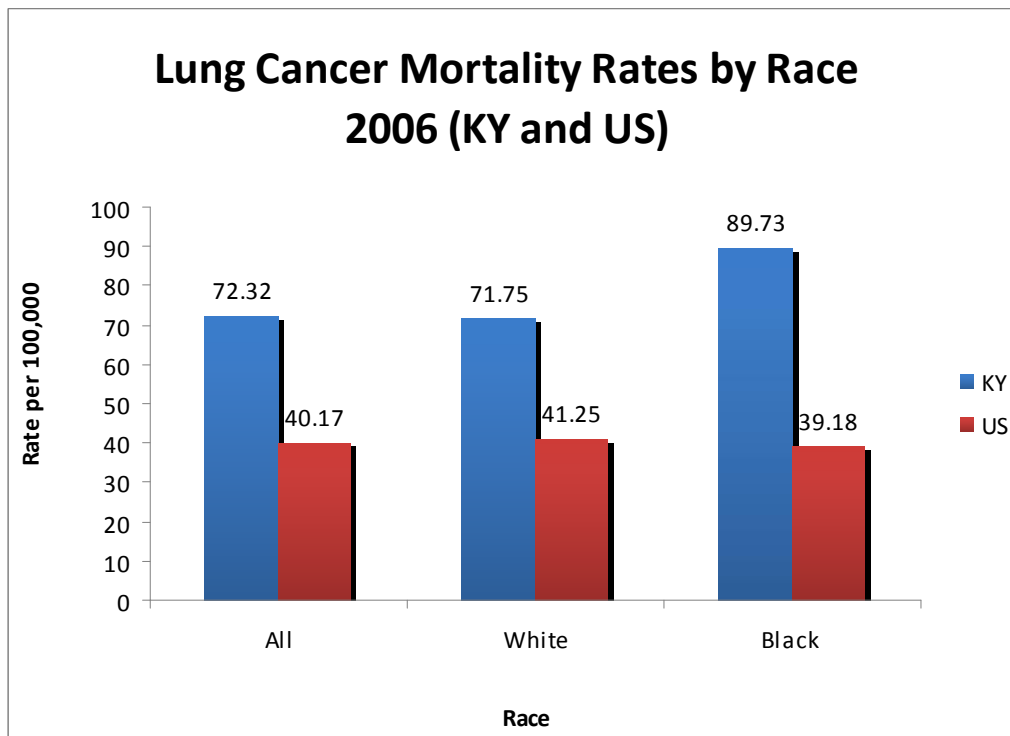
Figure 2.4: Cervical Cancer Mortality Rates by Race 2006 (KY and US)



The graph above illustrates the age-adjusted mortality rates for cervical cancer by race in Kentucky and the United States. According to the Kentucky Cancer Registry and the National Center for Health Statistics (NCHS), though the disparity is not as great in Kentucky as it is in the United States the cervical cancer mortality rate is somewhat higher among blacks than whites in Kentucky

Lung Cancer

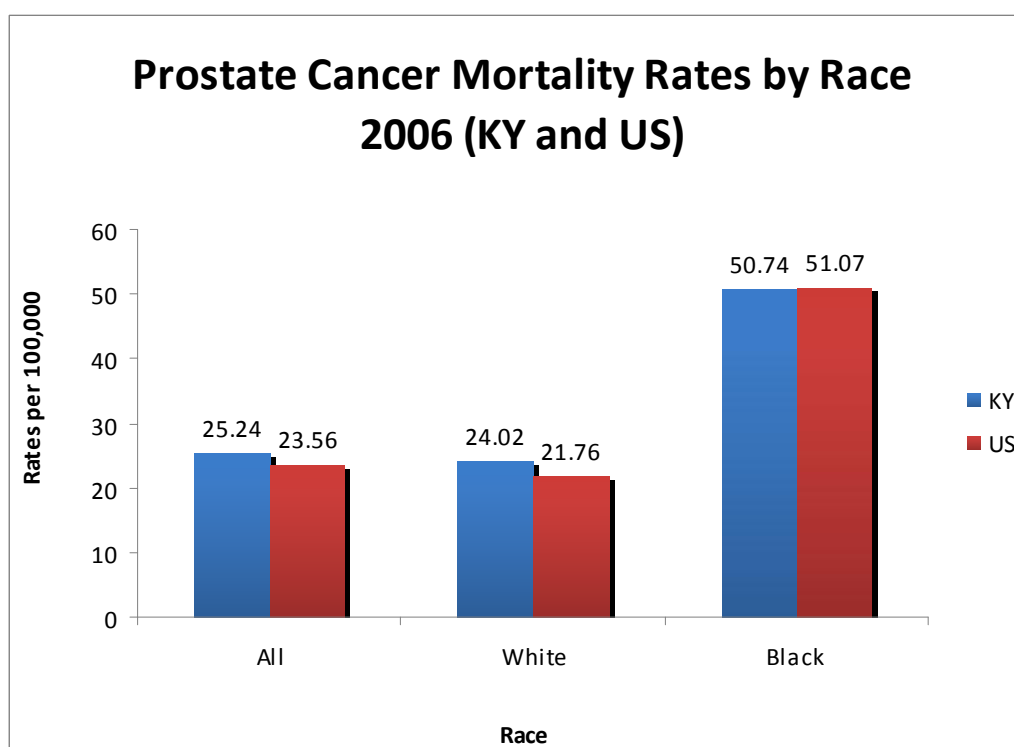
Figure 2.5: Lung Cancer Mortality Rates by Race 2006 (KY and US)



The graph above illustrates the age-adjusted mortality rates for lung cancer by race in Kentucky and the United States. According to the Kentucky Cancer Registry and the National Center for Health Statistics (NCHS), the lung cancer mortality rate is much higher, overall, in Kentucky than the United States. Unlike the nation as a whole, Kentucky has a higher lung cancer mortality rate among blacks compared to whites.

Prostate Cancer

Figure 2.6: Prostate Cancer Mortality Rates by Race 2006 (KY and US)



The graph above illustrates the age-adjusted mortality rates for prostate cancer by race in Kentucky and the United States. According to the Kentucky Cancer Registry and the National Center for Health Statistics (NCHS), the prostate cancer mortality rate is higher among blacks than whites in both Kentucky and the US.

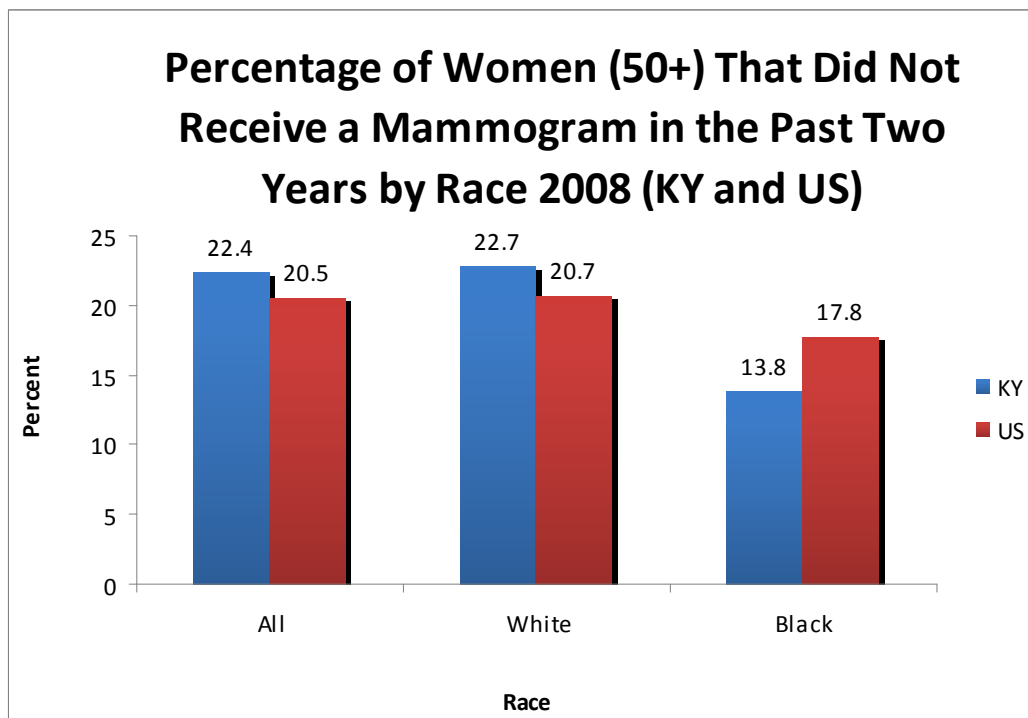
Limitations

Limitations to the Kentucky Cancer Registry Data include: incompleteness of treatment data and timeliness. There is incompleteness of treatment data (i.e. patients are often treated with multi-modality therapy in a variety of settings over time. Due to the confidential nature of the data being collected, it is often difficult to capture complete information on all treatments received. Additionally, hospitals are allowed six months from the date of initial contact with a patient before the cancer report is required to be sent to the registry. There is currently a delay of two years in establishing a “complete” annual database. Finally, the registry must rely on outside agencies to provide population estimates, contributing to the delay in data availability.

Cancer Screening/Prevention

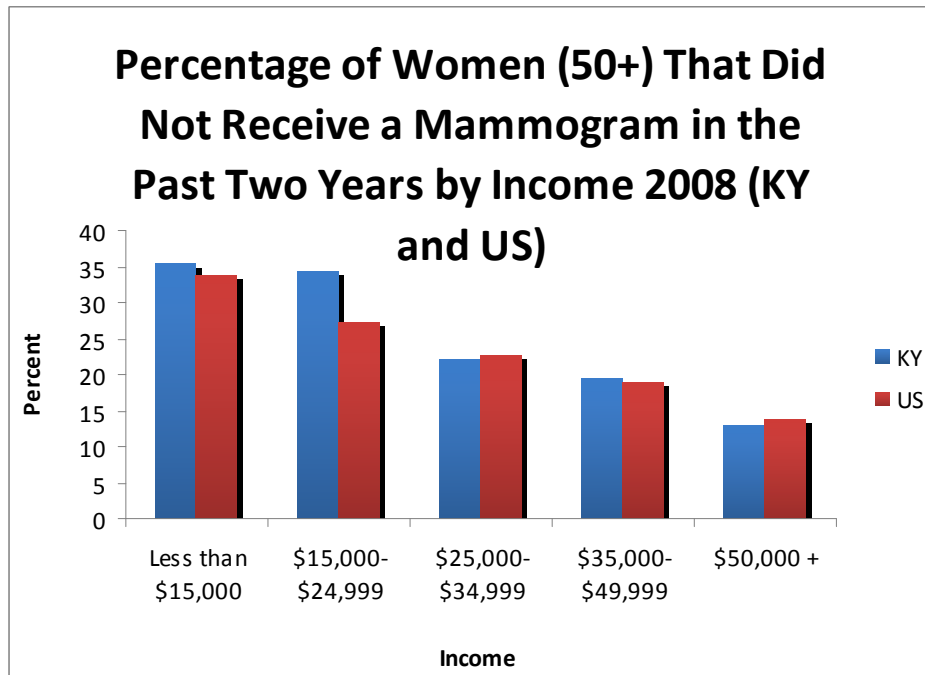
Mammograms

Figure 2.7: Percentage of Women (50+) That Did Not Receive a Mammogram in the Past Two Years by Race 2008 (KY and US)



The graph above illustrates the percentage of women, over 50, in Kentucky and the United States that did NOT receive a mammogram in the past two years by race. According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS), 22.7% of white women in Kentucky did not receive a mammogram while 13.8% of black women in Kentucky did not receive the service.

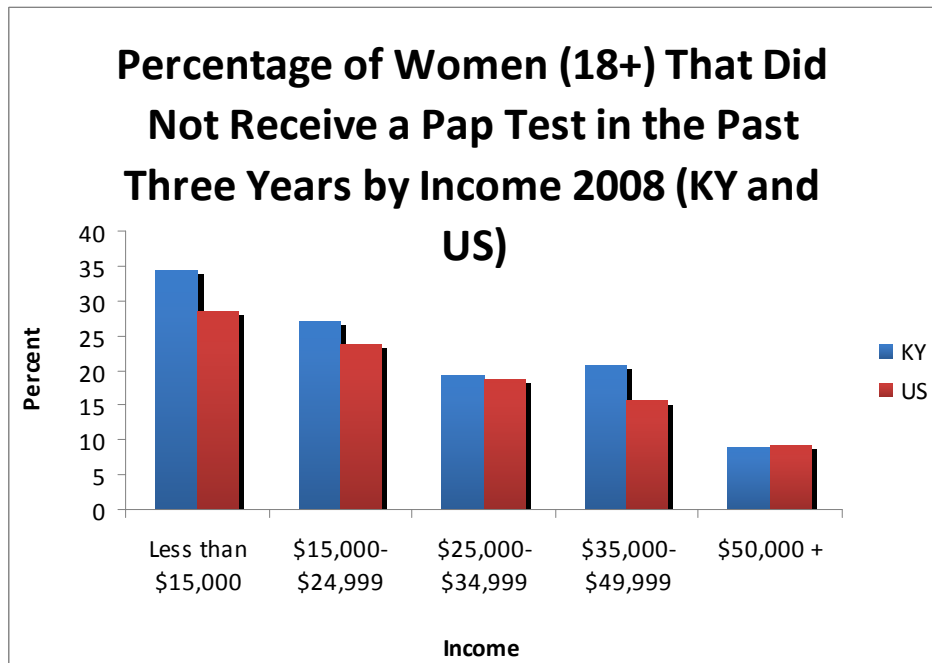
Figure 2.8: Percentage of Women (50+) That Did Not Receive a Mammogram in the Past Two Years by Income 2008 (KY and US)



The graph above illustrates the percentage of women, over 50, in Kentucky and the United States that did NOT receive a mammogram in the past two years by income level. According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS), rates of NOT receiving the service declines with increasing income for both women in Kentucky as well as nationally.

Pap smear

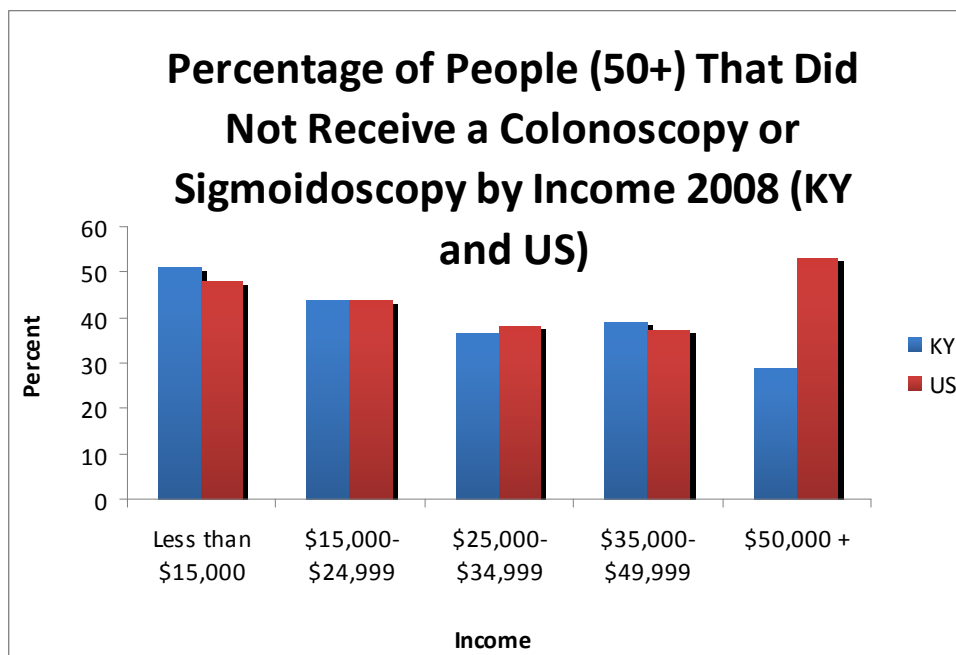
Figure 2.9: Percentage of Women (18+) That Did Not Receive a Pap Test in the Past Three Years by Income 2008 (KY and US)



The graph above illustrates the percentage of women, 18 and over, in Kentucky and the United States that did NOT receive a Pap test in the past three years by income level. Data on receipt of the service by race was not available for Kentucky. According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS), rates of NOT receiving the service declines with increasing income for both women in Kentucky as well as nationally.

Colonoscopy or Sigmoidoscopy

Figure 2.10: Percentage of People (50+) That Did Not Receive a Colonoscopy or Sigmoidoscopy by Income 2008 (KY and US)



The graph above illustrates the percentage of people, over 50, in Kentucky and the United States that have never received a colonoscopy or sigmoidoscopy by income. Data on receipt of the service by race was not available for Kentucky. According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS), rates of NOT receiving the service declines with increasing income for both women in Kentucky as well as nationally.

Limitations

There are two limitations to BRFSS data: non-coverage bias and self-report bias. According to the 2001 Census Population Estimate, 6.5% of Kentuckians were without telephones. This population is not reached and, therefore, not included in the survey. Those living in group settings (i.e. nursing homes, college dormitories, the military or prison) are not surveyed. Additionally, the BRFSS survey relies on self-report. This means prevalence estimates are strictly based on each respondent's answers which could potentially reflect a healthier lifestyle than what actually exists.

Sources

Kentucky Cancer Registry. Cancer Mortality Rates in Kentucky. Retrieved September 17, 2009, from <http://cancer-rates.info/ky/kymort.html>.

National Cancer Institute SEER. Underlying mortality data provided by National Center for Health Statistics.(n.d).Retrieved September 17, 2009, from <http://seer.cancer.gov/faststats/index.php>.Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System [Data file]. Retrieved September 16, 2009, from <http://apps.nccd.cdc.gov/brfss/>.

Behavioral Risk Factors

Smoking

Figure 2.11 : KY Adult Cigarette Smokers by Education Level 2008



The graph above illustrates the education level of adults in Kentucky who smoke cigarettes. According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS), 46% of KY smokers have less than a high school education. In comparison, only 9% of smokers have a college degree.

Limitations

There are some limitations to BRFSS data. The first limitation is non-coverage bias. This type of bias occurs when certain groups of people cannot be reached and thus are not included in the survey. The BRFSS survey is conducted using telephones, and therefore excludes individuals who do not have landline telephones in their homes. It also does not include those individuals who only have cell phones. The issue of excluding cell phones is presently being addressed. The exclusion of individuals without phones creates bias, because individuals without phones may have socio-economic differences from the survey population.

Another limitation of the BRFSS data is that of self-report bias. This type of bias occurs when individuals being surveyed over-estimate or under-estimate their risk behaviors. Individuals may report a healthier lifestyle than they actually have, which could influence prevalence estimates.

These limitations should not hinder the use of BRFSS data, but should be considered.

Figure 2.12: KY Adult Cigarette Smokers by Race 2008



Source: Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System [Data file]. Retrieved from

<http://apps.nccd.cdc.gov/brfss/education.asp?cat=TU&yr=2008&qkey=4396&state=KY>

The graph above illustrates the percentage of adult smokers in Kentucky by race. According to the 2008 BRFSS survey, 28% of adult smokers in Kentucky are African-American, followed by whites (25%), and Hispanics (18%).

Overweight and Obesity

Table 2.4: Overweight and Obesity Rates for KY 2008 by Race

Race	KY %	US %
White	64.7%	59.6%
Black	73.7%	69.9%
Hispanic	48.7%	62.1%
Other	69.8%	59.5%

Note: Percentages are weighted to reflect population characteristics

Source: 2008 Kaiser Family Foundation Data

According to the 2008 Behavioral Risk Factor Surveillance System, Blacks had the highest rate of obesity and overweight (defined as having a Body Mass Index [BMI] greater than or equal to 25 kg/meters squared) followed by Whites and Hispanics. The rates of overweight and obesity

combined for both Blacks and Whites in Kentucky exceeded national trends, while the rates for Hispanics were well below the national rates. Blacks were almost 14% more likely to be either obese or overweight than Whites.

High Blood Pressure

Table 2.5: Adults who have had their blood pressure checked and told it was high, by Race/Ethnicity in KY

Race	% Adults Reporting YES to Hypertension	% of Adults Reporting NO to Hypertension
White	29.7% (CI: 28.1-31.3) n=2586	70.3% (CI: 68.7-71.9) n=3861
Black	32.4% (CI: 23.8-41.0) n=101	67.6% (CI: 59.0-76.2) n=129
Hispanic	N/A	N/A
Other	N/A	N/A

Source: 2007 Behavioral Risk Factor Surveillance Survey Data

According to the 2007 Behavioral Risk Factor Surveillance System, the estimated prevalence of hypertension is 2.7% higher among Blacks than it is among Whites in Kentucky.

High blood cholesterol

Table 2.6: Adult who have had their blood cholesterol checked and told it was high, by Race/Ethnicity in KY

Race	% Adults Reporting YES to High Cholesterol	% Adults Reporting NO to High Cholesterol
White	39.3% (37.3-41.3) n=2468	60.7% (58.7-62.7) n=2935
Black	29.7% (20.9-38.5) n=75	70.3% (61.5-79.1) n=117
Hispanic	N/A	N/A
Other	N/A	N/A

Source: 2007 Behavioral Risk Factor Surveillance Survey Data

According to the 2007 Behavioral Risk Factor Surveillance System, the estimated prevalence of high cholesterol was 9.6% higher among Whites than it is among Blacks in Kentucky.

Injury

Figure 2.13. Trauma cases by county, 12 year period, 1995-2006.

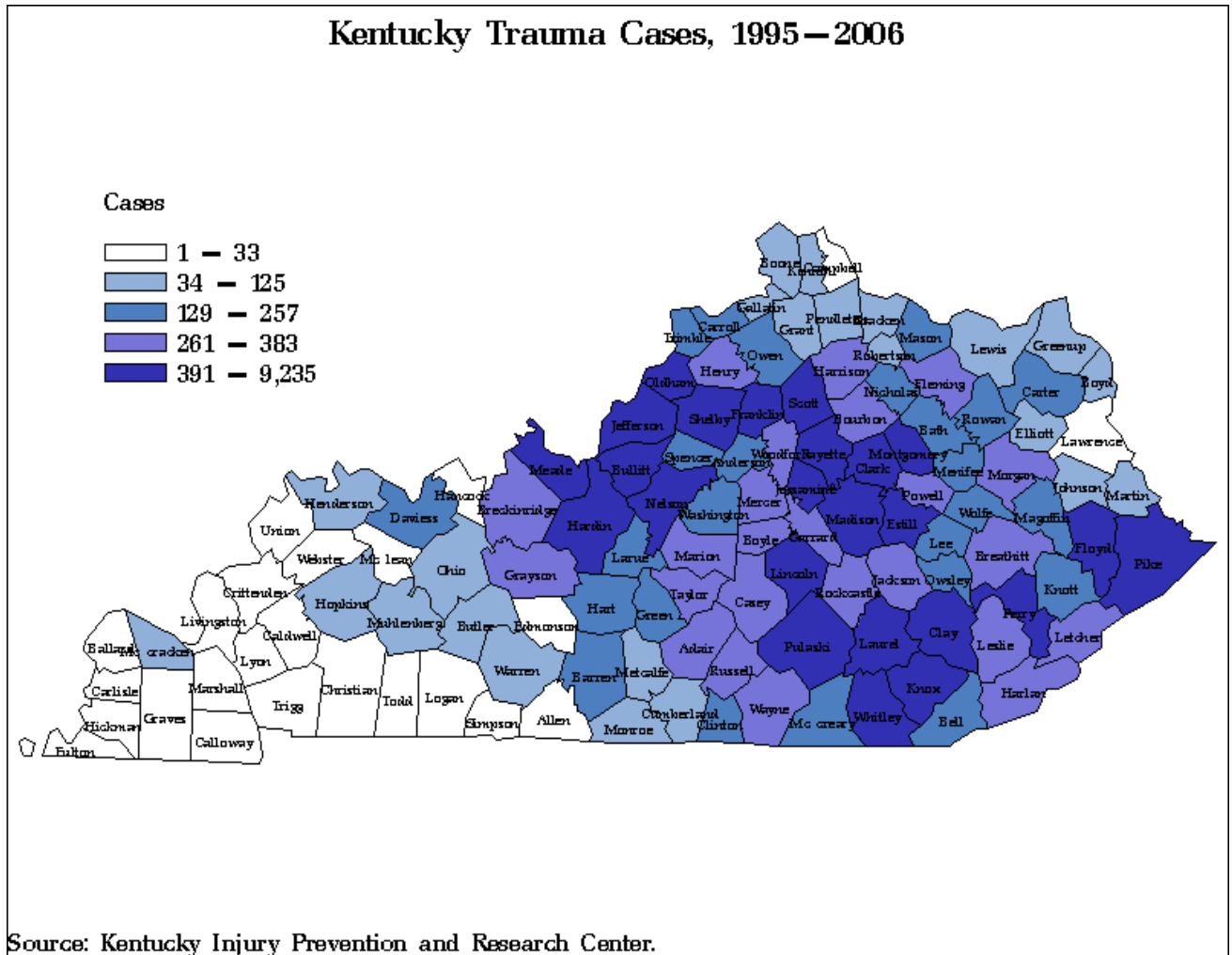


Figure 2.14: Crude trauma rates by county, 12 year period, 1995-2006.

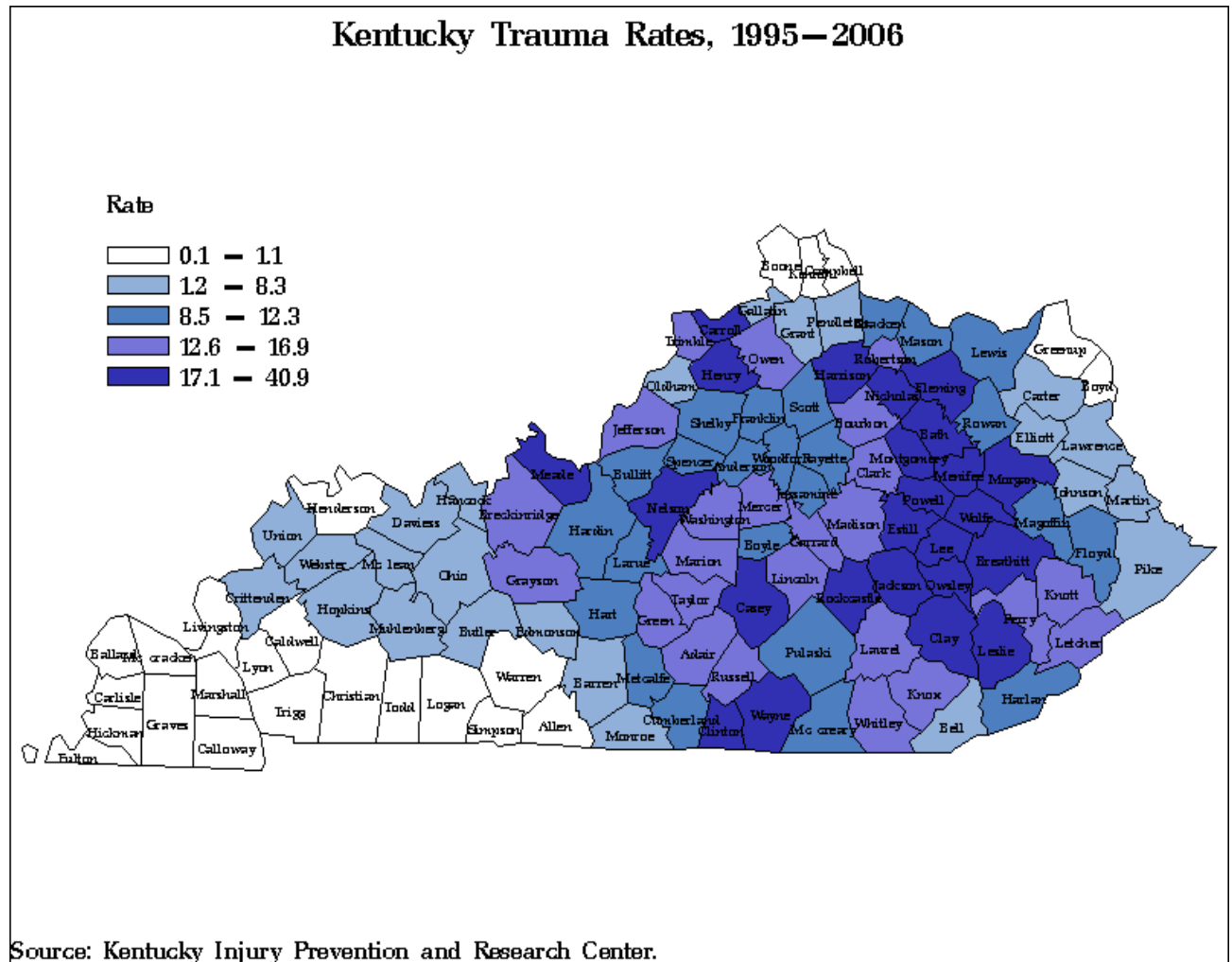


Table 2.7. Race (percent) by hospital for Trauma Patients.

Source: Kentucky Injury Prevention and Research Center

University of Kentucky

	Caucasian	African-American	Hispanic	Other	Missing
1995	94.3	4.3	0.8	0.5	0.0
1996	93.0	5.0	1.5	0.4	0.0
1997	93.2	5.3	1.4	0.1	0.0
1998	93.8	3.6	2.4	0.2	0.0
1999	93.7	3.9	2.3	0.2	0.0
2000	94.1	3.1	2.5	0.2	0.0
2001	94.0	3.2	2.7	0.2	0.0
2002	94.1	2.8	2.9	0.2	0.0
2003	93.3	3.9	2.7	0.2	0.0
2004	93.5	3.0	3.0	0.4	0.0
2005	93.4	3.1	2.8	0.3	0.4
2006	93.3	3.2	2.7	0.2	0.7
Average	93.6	3.7	2.3	0.3	0.1

University of Louisville

	Caucasian	African-American	Hispanic	Other	Missing
1995	80.6	17.4	1.2	0.7	0.1
1996	80.2	17.7	1.2	0.5	0.4
1997	80.3	16.8	2.0	0.7	0.2
1998	84.1	13.6	0.7	1.7	0.0
1999	81.8	14.9	1.1	2.2	0.0
2000	81.9	14.0	1.5	2.6	0.1
2001	82.1	12.9	1.1	3.9	0.0
2002	83.9	11.9	1.2	2.9	0.1
2003	83.6	12.2	1.7	2.6	0.0
2004	80.8	14.2	1.8	3.2	0.0
2005	79.6	14.8	2.2	3.2	0.1
2006	81.1	14.0	2.3	2.7	0.0
Average	81.7	14.5	1.5	2.2	0.1

Kosair Children's Hospital

	Caucasian	African-American	Hispanic	Other	Missing
1995	77.1	20.4	0.0	2.6	0.0
1996	82.5	17.0	0.0	0.5	0.0
1997	77.0	21.6	0.0	1.4	0.0
1998	75.4	21.8	0.0	2.8	0.0
1999	79.3	17.6	0.0	3.1	0.0
2000	77.7	18.8	0.0	3.5	0.0
2001	82.6	13.7	2.0	1.5	0.2
2002	81.2	15.3	1.6	1.9	0.0
2003	83.3	14.1	1.9	0.6	0.2
2004	81.5	13.6	2.6	2.3	0.0
2005	81.1	13.8	2.7	2.5	0.0
2006	84.4	12.1	2.5	0.9	0.0
Average	80.3	16.6	1.1	2.0	0.0

Table2.7 (continued.) Race (percent) for all reporting facilities

Combined Hospitals

	Caucasian	African-American	Hispanic	Other	Missing
1995	87.1	11.2	0.9	0.8	0.0
1996	87.0	11.2	1.3	0.4	0.2
1997	86.9	11.1	1.5	0.5	0.1
1998	88.4	9.0	1.5	1.0	0.0
1999	87.7	9.4	1.6	1.3	0.0
2000	87.2	9.4	1.8	1.6	0.0
2001	87.9	8.2	2.0	1.8	0.0
2002	88.3	8.2	2.0	1.5	0.0
2003	87.8	8.8	2.1	1.3	0.0
2004	87.3	8.5	2.5	1.7	0.0
2005	87.6	8.0	2.6	1.4	0.3
2006	88.1	7.9	2.5	1.1	0.3
Average	87.6	9.3	1.9	1.2	0.1

The combined data for all hospitals and all years shows that a large majority (87.6%) of all trauma patients were Caucasian, 9.3% of all patients were African-American, and 1.9% of patients were Hispanic. The average percentage of Hispanic patients in all trauma centers is 1.9%, but UKH sees a larger percentage at 2.3%. KCH and ULH see a much higher percentage of African-American trauma patients in their hospitals (16.6% and 14.5%) than does UKH (3.7%), reflecting the much higher proportion of African-Americans in the Metro Louisville population.

The Caucasian proportion of trauma cases has remained relatively stable across the eight years of data, and the African-American proportion has steadily decreased. While the numbers are not large, an increase in the Hispanic population can be seen across the twelve years of data, a trend that should be recognized for translation and other resource planning. Totals may not add to 100% in tables 5 and 6 due to rounding.

The 2000 Census reports that 90% of all Kentuckians identify themselves as Caucasian, slightly higher than the trauma registry average of 87.6%. Conversely, the proportion of African-

Americans in the trauma registry, 9.3%, is substantially higher than the 7.3% African-Americans in the census data. Census data on the Hispanic population, widely judged to be a significant undercount, indicates that they represent 1.4% of the state's population, while the trauma registry shows an average of 1.9%. A disproportionate burden of trauma on racial and ethnic minorities appears in Kentucky as well as nationally. For this reason, additional information is included on the following page.

Race

African-American Data Summary

A total of 4,570 African-American patients received care at the three level one trauma hospitals. Their mean age was 29.3 years with a median age of 27 which shows a somewhat younger population than the entire trauma database (mean age 33.6 with a median age of 31). 27.7% of African-American trauma registry patients were under the age of 18 vs 23.3% trauma registry patients as a whole.

The leading cause of injury for African-American trauma registry patients (as for all registry patients) was motor vehicle crashes, though at a lower rate than the trauma database as a whole (44.1% vs 59.4%, respectively). Assault/homicide was the second leading cause of trauma injury for African-Americans with a significantly higher rate (28.1%) than for the entire trauma database (8.3%). Falls, though still one of the leading causes of injury, were slightly lower for this population (8.9%) than the population as a whole (13.3%).

Deaths for African American trauma patients (9.7%) were slightly higher than the database as a whole (7.7%). This also appeared to be a younger population with African-American trauma patients who died having a mean age of 33.4 and a median age of 30 while overall the mean age for deaths in the trauma database was 43.4 with a median age of 41. Just under one third (32.7%) of these deaths were assault/homicide related. This number was much higher than the trauma population as a whole with only 9.4% of deaths being assault/homicide related.

Hispanic Data Summary

A total of 943 Hispanic trauma registry patients received care at the three level one trauma hospitals. Their mean age was 28 years with a median age of 27, and this was also a younger population than the trauma patients as a whole. Conversely, only 14.7% of Hispanic trauma registry patients were under the age of 18 vs 23.3% of the registry overall. Males comprised an even higher percentage of the Hispanic population (87.9%) than the already high rate of males in the entire trauma population.

The leading causes of injury for Hispanics were motor vehicle crashes (49.7%), followed by assault/homicide (19.2%) and falls (14.4%). Both assault/homicide and fall rates were higher than the trauma population as a whole (8.3% and 13.3%, respectively).

Trauma registry cases resulted in death for 7.6% of Hispanic patients. While closer to the overall death rate, these deaths are occurring even younger than the African-American population with a

mean age of 27.7 and a median age of 27. Occupants in car crashes are the leading cause of death for the Hispanic trauma patients with homicide being the second leading cause of death with 15.3%. As with the African-American trauma patients, this rate is higher than the trauma population as a whole.

Infections and Sexually Transmitted Diseases

HIV/AIDS

Table 2.9: Cumulative AIDS Cases by Age at Diagnosis, Race/Ethnicity, and Sex through December 31, 2008

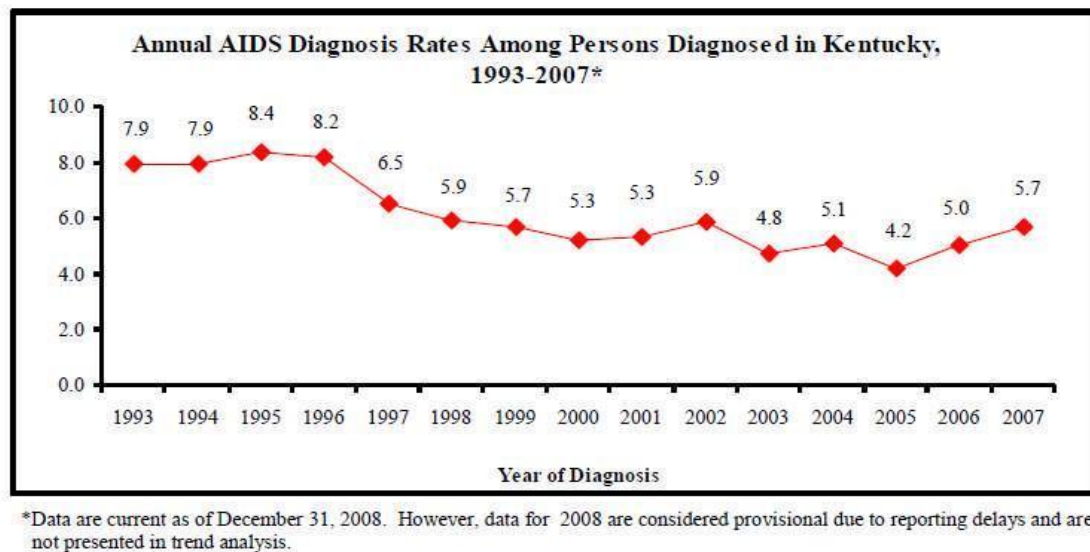
Cumulative ⁽¹⁾ AIDS Cases By Age at Diagnosis, Race/Ethnicity, and Sex through December 31, 2008											
	Age Group	White, Not Hispanic		Black, Not Hispanic		Hispanic		Other/Unknown		TOTAL	
		No.	%	No.	%	No.	%	No.	%	No.	% ⁽²⁾
MALE	<13	7	≤1%	14	1%	0	0%	0	0%	21	0%
	13-19	17	1%	10	1%	2	1%	0	0%	29	1%
	20-29	473	16%	212	18%	39	29%	2	11%	726	17%
	30-39	1251	44%	484	41%	63	47%	6	33%	1804	43%
	40-49	801	28%	349	29%	21	16%	9	50%	1180	28%
	50+	326	11%	124	10%	9	7%	1	6%	460	11%
	TOTAL⁽²⁾	2875	100%	1193	100%	134	100%	18	100%	4220	100%
FEMALE	<13	7	2%	6	2%	0	0%	0	0%	13	2%
	13-19	4	1%	2	1%	1	3%	0	0%	7	1%
	20-29	76	21%	75	19%	16	47%	3	33%	170	21%
	30-39	145	40%	164	42%	8	24%	3	33%	320	40%
	40-49	84	23%	102	26%	6	18%	3	33%	195	25%
	50+	47	13%	40	10%	3	9%	0	0%	90	11%
	TOTAL⁽²⁾	363	100%	389	100%	34	100%	9	100%	795	100%

(1) Includes both Adult/Adolescent and Pediatric AIDS cases.

(2) Percentages may not total 100 due to rounding.

Since the start of the epidemic in the early 80's more cases have been reported among males (84%) than females. Sex specific prevalence indicates that a higher number of cases among females living in Kentucky at the time of diagnosis have been reported in black women (n=389) in comparison to other races.

Figure 2.15: Annual AIDS Diagnosis Rates Among Persons Diagnosed in Kentucky 1993-2007



The annual AIDS diagnosis rate among persons in Kentucky shows a trend by year of diagnosis. The annual AIDS diagnosis rate has remained fairly steady from 2000 to 2007, with slight fluctuations. In 2007, there were 5.7 persons per 100,000 populations in Kentucky that were diagnosed with AIDS.

Figure 2.16: HIV Incidence by Race vs. Kentucky Population-2007

New HIV cases in Kentucky 2007 Kentucky Population 2008

1



On average from 2003-2007, the AIDS Diagnosis rates per 100,000 population for Blacks was approximately eight times higher than for Whites and five times higher for Hispanics than for Whites in Kentucky. This further highlights the disproportionate impact of AIDS on minorities in Kentucky.

Figure 2.17: Kentucky AIDS Diagnosis Rates by Race/Ethnicity and Year of Diagnosis, 2003-2007

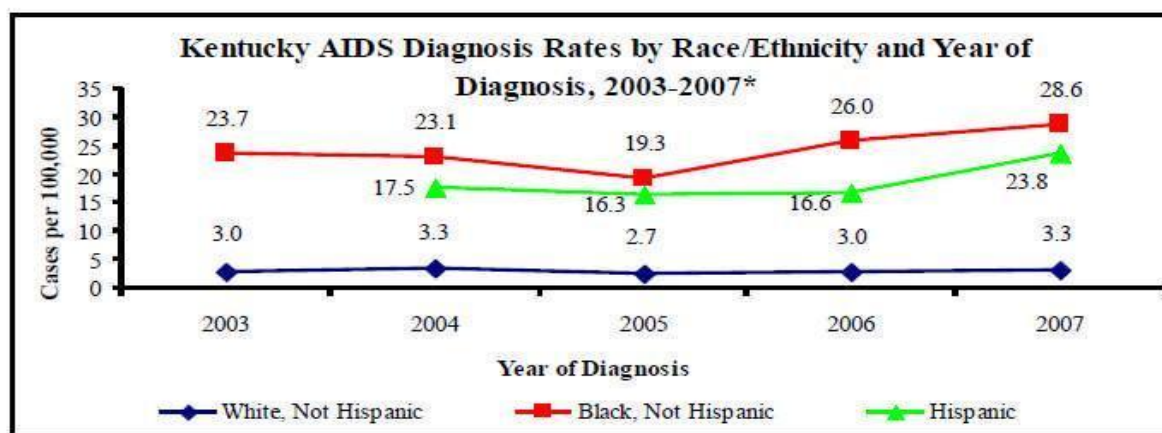
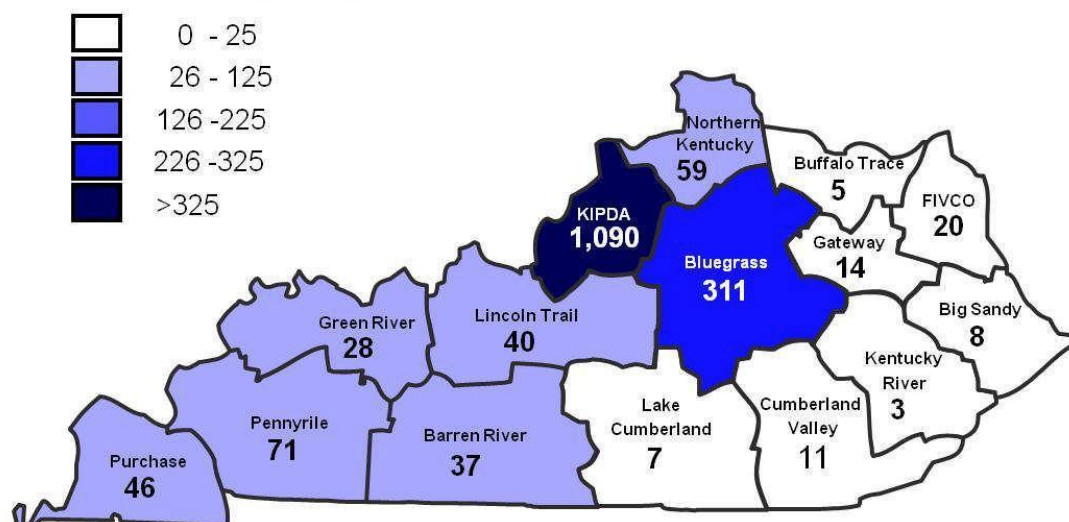


Figure 2.18: Cumulate AIDS Cases among Black non-Hispanic and Hispanics by ADD

Cumulative AIDS Cases among Black non- Hispanic and Hispanics by Area Development District (ADD) of Residence at Time of Diagnosis through December 31, 2008

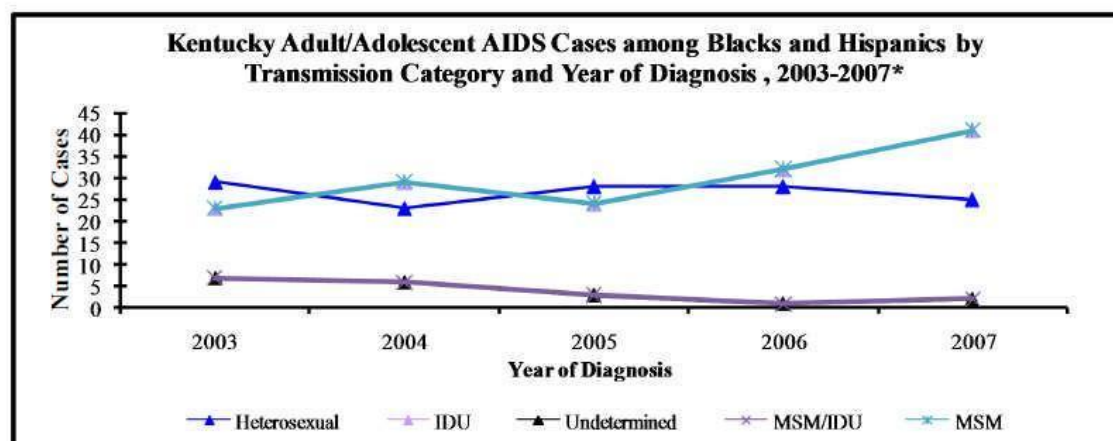
Cumulative AIDS Diagnoses by ADD



Cumulatively, the majority of AIDS cases diagnosed in Kentucky among minorities (Blacks and Hispanics) were living in KIPDA ADD at the time of diagnosis (n=1,090), which includes the city of Louisville. The area with the second largest number of AIDS cases is the Bluegrass ADD (n=311), which includes Lexington city.

The trend from 2003-2007 shows that the mode of transmission of HIV among minorities (Blacks and Hispanics) in Kentucky is through having sex with other men (MSM) and heterosexually, with a partner who has HIV or is at high risk for HIV infection.

Figure 2.19: Kentucky Adult/Adolescent AIDS Cases among Blacks and Hispanics by Transmission Category and Year of Diagnosis, 2003-2007



*Data for 2008 are not included in trend analyses since they are considered provisional due to reporting delays; all data are subject to change due to reporting delays.

Sexually Transmitted Diseases

Chlamydia

Chlamydia impacts youth ages 15-24 years greater than other populations in the state of Kentucky. African Americans are also at higher risk of Chlamydia when comparing incidence case by case.

In 2008 there were a total of 12,162 Chlamydia cases reported in Kentucky. There were 8,623 females, and 3,506 males identified with the disease. The following accounts the % of cases reported based on race/ethnicity:

Asian n= 33, (0%)

African Americans n= 3508, (29%)

Hispanics n = 260, (2%)

American Indian n = 16, (0%)

Whites n = 4042, (33%)

Unknown/Other n = 4303, (35%)

Total n = 12, 162, (100%)

Gonorrhea

Gonorrhea disproportionately impacts African Americans in Kentucky when comparing case rates.

In 2008 there were a total of 4,548 Gonorrhea cases reported in Kentucky. There were a total of 2,510 females and 2,031 males identified with the disease. The following accounts the % of cases reported based on race/ethnicity:

Asian n= 16, (0%)

African Americans n= 2179, (48%)

Hispanics n = 48, (1%)

American Indian n = 3, (0%)

Whites n = 1002, (22%)

Unknown/Other n = 1300, (29%)

Total n = 4,548, (100%)

Syphilis

Syphilis is found more among males than females and disproportionately impacts African Americans in Kentucky.

In 2008 there were a total of 218 Syphilis cases reported in Kentucky. There were a total of 52 females and 166 males identified with the disease. The following account for the % of cases reported based on race/ethnicity:

Asian n= 1, (0%)

African Americans n= 64, (29%)

Hispanics n = 15, (7%)





American Indian n = 0, (0%)

Whites n = 117, (54%)

Unknown/Other n = 21, (10%)

Total n = 218, (100%)

Figure 2.20: Kentucky Sexually Transmitted Disease Rate/ 100,000 for 2006

State 	Disease	Count 	Population 	Rate Per 100,000 
Kentucky (21)	Chlamydia	8,940	4,206,074	212.55
	Gonorrhea	3,277	4,206,074	77.91
	Total Syphilis	188	4,206,074	4.47

Source: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention (NCHSTP), Division of STD/HIV Prevention, Sexually Transmitted Disease Morbidity 1984 - 2006, CDC WONDER On-line Database, November 2008. Accessed at <http://wonder.cdc.gov/std-v2006.html> on Sep 29, 2009 12:01:09 PM

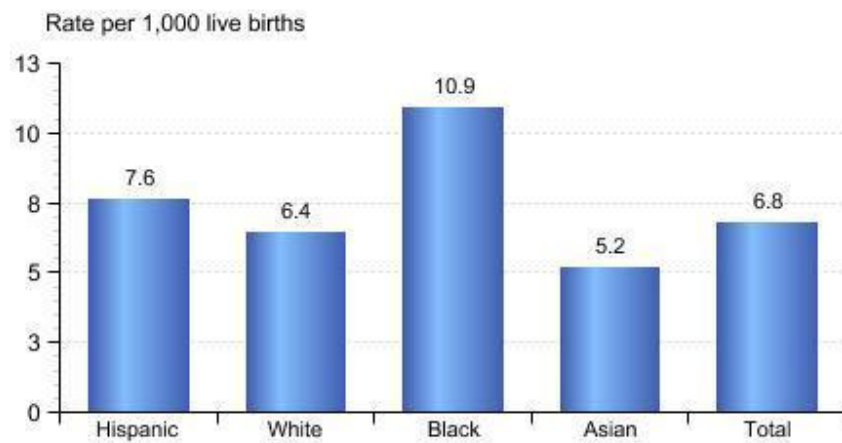
Maternal and Child Health

During 2004-2006 (average) in Kentucky, preterm birth rates were highest for black infants (19.5%), followed by whites (14.5%), Native Americans (13.4%) and Asians (11.7%).

Black infants (19.5%) were about 2 times as likely as Asian infants (11.7%) to be born preterm during 2004-2006 (average).

In the United States, prematurity/low birthweight is the second leading cause of all infant deaths (during the first year of life) and the leading cause of infant death among black infants.

Figure 2.21: Infant Mortality Rates by Race/Ethnicity: Kentucky, 2003-2005 Average



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Oral Health

Figure 2.22 : Adults aged 18+ who have visited a dentist or dental clinic in the past year 2004

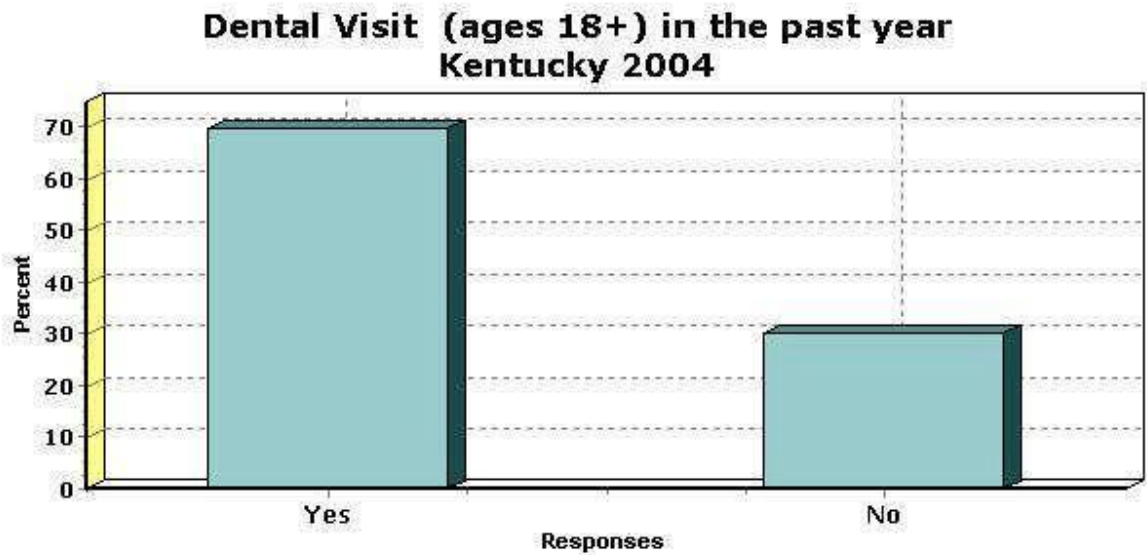


Figure 2.23: Dentist Visit and Age

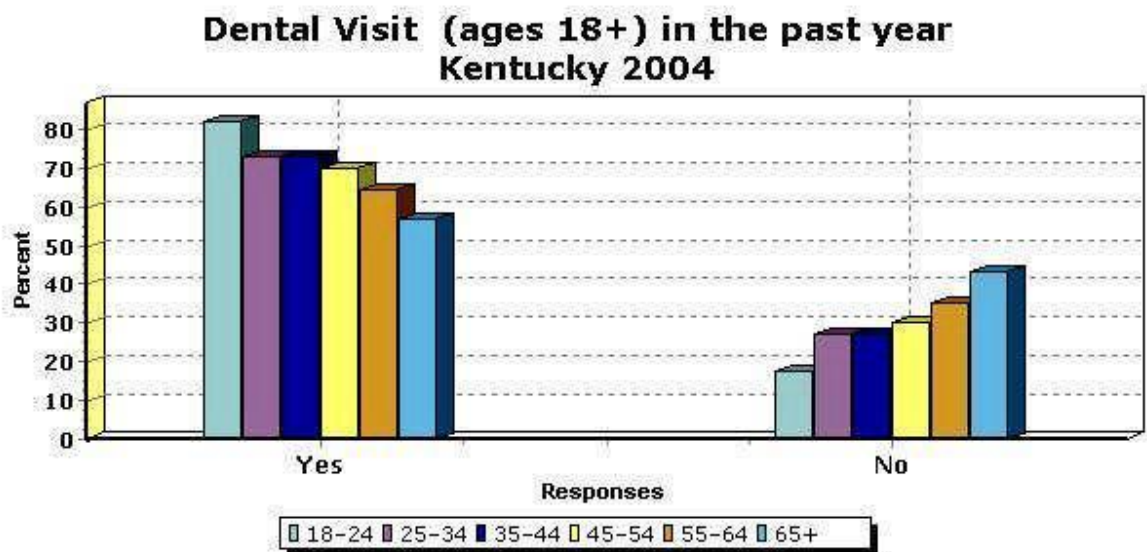


Figure 2.24: Dental Visit and Education

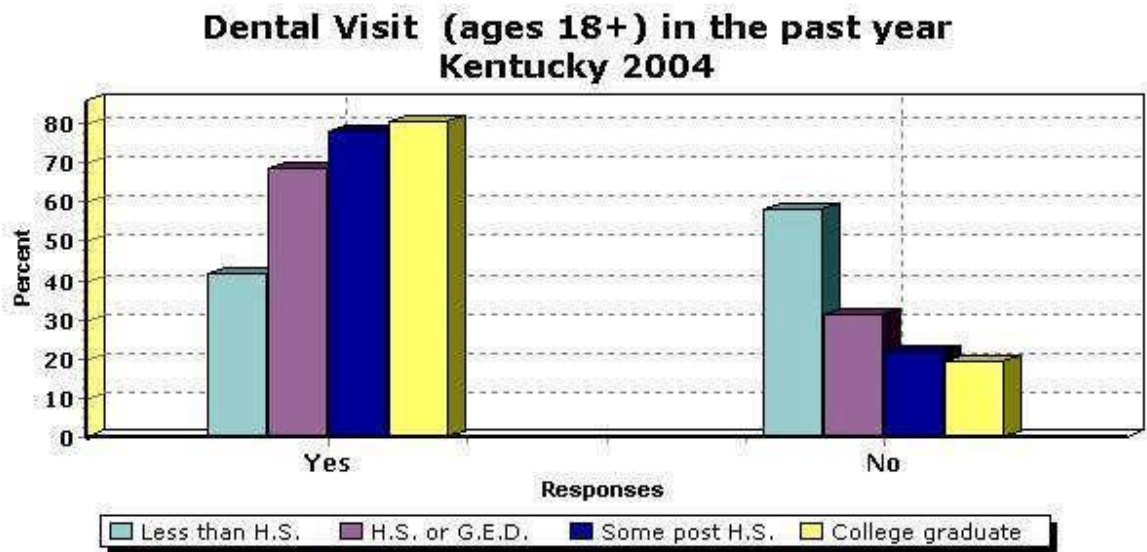


Figure 2.25: Dentist Visit and Gender

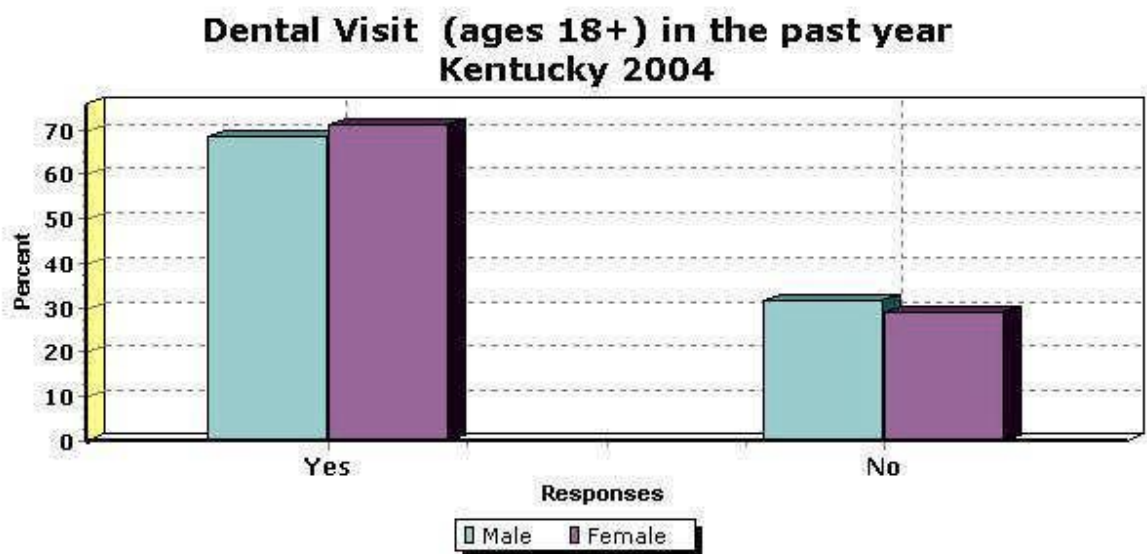


Figure 2.26: Dental Visit and Income

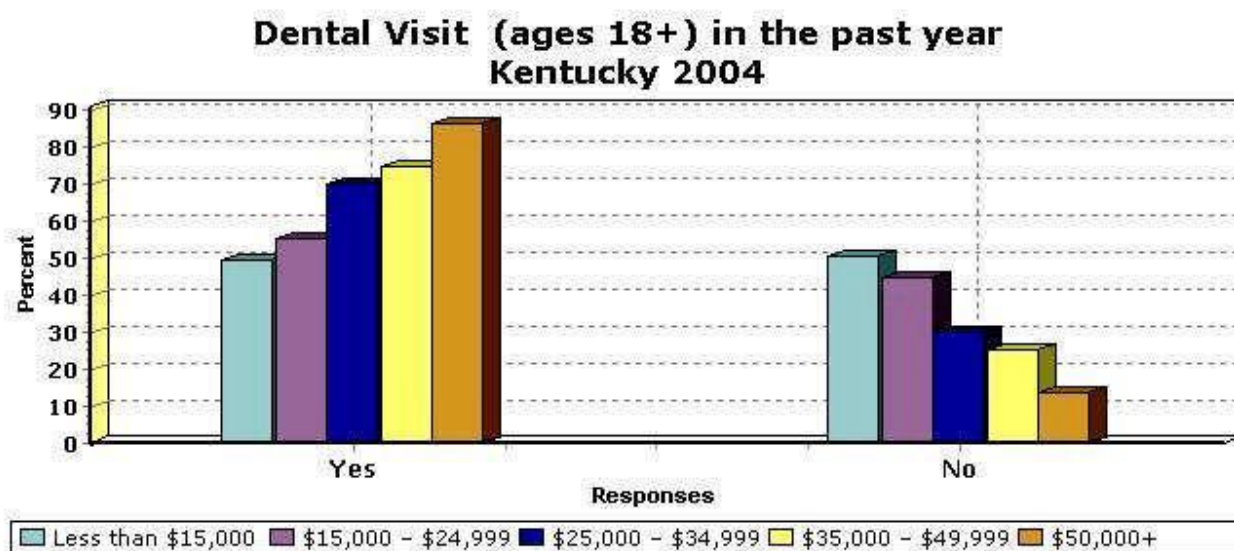
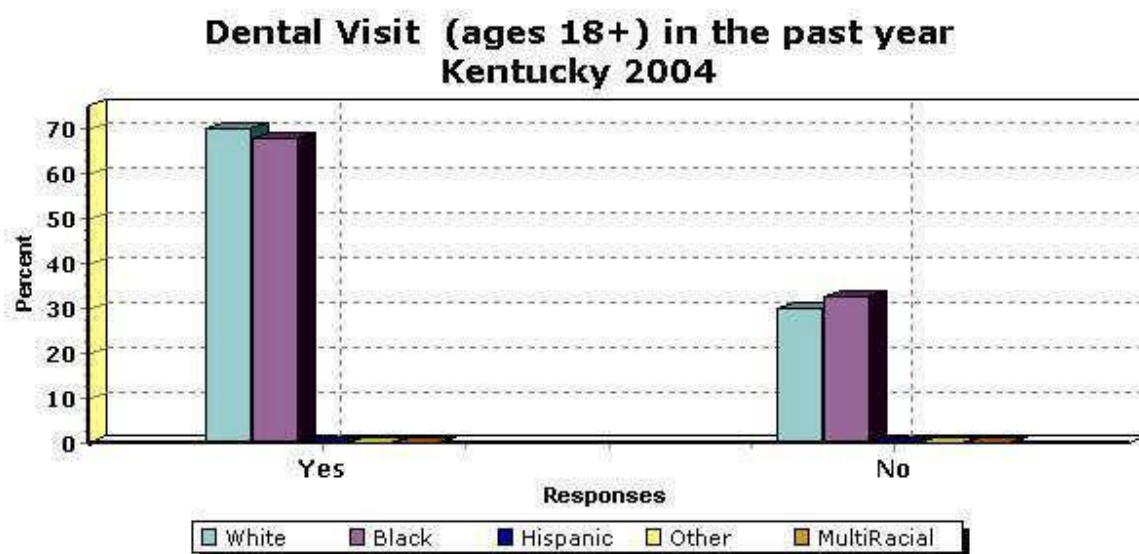


Figure 2.27: Dental Visit and Race



Source: Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion, National Oral Health Surveillance System. Accessed at <http://www.cdc.gov/nohss/DSMain.htm> on September 29, 2009.

Uninsured

Table 2.19: Uninsured Rates for the Nonelderly by Race/Ethnicity in KY (2006-2007) compared to US (2007)

Race	KY (#)	KY (%)	US (#)	US (%)
White	485,240	15.2%	20,264,170	12.2%
Black	62,930	22.6%	6,941,040	20.9%
Hispanic	35,150	39.4%	14,558,420	33.5%
Other	N/A	N/A	3,207,150	17.7%
Total	597,950	16.4%	44,970,780	17.2%

According to the Kaiser Family Foundation in 2007, nonelderly (individual aged 0-64 years of age) Hispanics had the highest rates of being without insurance coverage and were almost 2.6 times more likely than nonelderly whites to be without insurance in Kentucky. Nonelderly Blacks were almost 1.5 times more likely than elderly whites to be uninsured. The uninsured rate in Kentucky was higher than the national trends for each demographic.

Table 2.20 (%) Individuals under 65 years of age that are uninsured by Race and Income Level in KY (US Census Bureau, 2006)

	Number Uninsured	Percent Uninsured in Demographic Group	Margin of Error
All income levels:	570,294	15.6%	0.8
White	465,437	14.6%	0.8
Black	58,313	20.6%	1.9
Hispanic	30,978	35.1%	2.9
At or below 200% poverty level	352,477	27.8%	1.6
White	281,888	27.3%	1.8
Black	39,004	26.3%	2.8
Hispanic	21,987	42.4%	3.9
At or below 250% poverty level	410,284	25.6%	1.5
White	329,585	24.8%	1.6
Black	44,403	25.4%	2.5
Hispanic	24,960	41.6%	3.6

According to estimates from the US Census Bureau in 2006, among individuals of all income levels in Kentucky combined, Hispanics had the highest proportion of uninsured individuals at

35%, followed by Blacks at 20.6% and Whites at 14.6%. Among individuals at or below 200% poverty level in Kentucky, Hispanics had a much higher proportion of uninsured individuals at 42.4% than did Blacks or Whites. Among the individuals at or below 250% poverty level, Hispanics had a much higher proportion of uninsured individuals in this subgroup than the proportion of Black or Whites.

Table 2.21: (%) Individuals under 19 years of age all races combined that are uninsured by Income Level in KY (US Census Bureau, 2006)

	Number Uninsured	Percent Uninsured in Demographic Group	Margin of Error
All income levels	94,741	9.0%	1.1
At or below 200% poverty level	60,209	13.4%	1.8

KCHIP

Table 2.22: Number of children enrolled in KCHIP at the end of the calendar year (KY Dept of Medicaid Services, 2009)




Year	Number of Children Enrolled in KCHIP
2008	53,836
2007	52,319
2006	51,138
2005	50,785
2004	49,638
2003	51,381
2002	50,340

Note: The number of children measured in December for the specified calendar year.

PART III

Hospital Inpatient Discharge and Outpatient Services Administrative Claims Data.

Provided by Office of Health Policy

-  INPATIENT HOSPITAL DISCHARGES AND OUTPATIENT SERVICES
-  INPATIENT QUALITY INDICATOR FOR CESAREAN DELIVERY RATE
-  HOSPITAL DISCHARGE AND UTILIZATION OF EMERGENCY DEPARTMENT FOR SPECIFIC CONDITIONS

Hospital Inpatient Discharge Administrative Claims Data and Outpatient Services Administrative Claims Data

All data presented in this section was gathered using administrative claims data for Inpatient Hospital Discharges and Outpatient Services with dates of service between January 1, 2008 through December 31, 2008. Data was gathered by the Office of Health Policy.

Inpatient Hospital Discharges and Outpatient Services

Effective with inpatient hospital discharges occurring on or after January 1, 2008 and outpatient services performed by hospitals or ambulatory surgery centers on or after January 1, 2008, facilities began submitting data on the race and ethnicity of patients served. For the first time, analysis can be conducted in these areas. During 2008, there were a total of 587,659 inpatient hospital discharges and 2,879,357 outpatient services visits which include 1,652,618 emergency department visits¹. (Note that an emergency department visit means a patient is seen in an emergency department and released or held for an observation stay only. This count will not include patients that are admitted to the hospital via an emergency room, admitted for outpatient surgery via an emergency room, registered via an emergency for a mammogram, etc.)

¹ 2008 Inpatient Hospital Discharge, Outpatient Services, and Emergency Department data provided by the Office of Health Policy, Cabinet for Health and Family Services.

The 2008 population estimates for Kentucky² indicate total population of 4,269,245, of which 87.78% are white, 7.57% are African American, 2.39% are Hispanic, and 2.26% are Asian or other. Due to the small numbers of Asian and other, this analysis will focus on the white, African American, and Hispanic population. The following chart compares the percentage of Inpatient Hospitalization, Emergency Department Utilization, and Outpatient Services Utilization by race/ethnicity as compared to the population.

Figure 3.1: Utilization of services by race/ethnicity as compared to Population



² 2008 Population estimates obtained from the Kentucky State Data Center at <http://ksdc.louisville.edu/>.

The following provides a per 100,000 population inpatient hospital discharge comparison of whites, African Americans, and Hispanics. Whites utilize inpatient hospital services the most at 13,846 per 100,000 population. Hispanics are hospitalized 22% less often than whites, and African Americans are hospitalized 8% less often than whites.

Figure 3.2: 2008 Inpatient Hospital Discharges Per 100,000 Population



The following provides a per 100,000 population emergency department utilization comparison of whites, African Americans, and Hispanics. African Americans utilize emergency department services the most at 47,657 per 100,000 population. Hispanics utilize emergency departments 55% less often than African Americans, and whites utilize emergency departments 21% less often than African Americans.

Figure 3.2: 2008 Emergency Department Utilization Per 100,000 Population



The following provides a per 100,000 population outpatient services utilization comparison of whites, African American, and Hispanics. African Americans utilize outpatient services the most at 70,327 per 100,000 population. Hispanics utilize outpatient services 57% less often than African Americans, and whites utilize outpatient services 5% less often than African Americans.

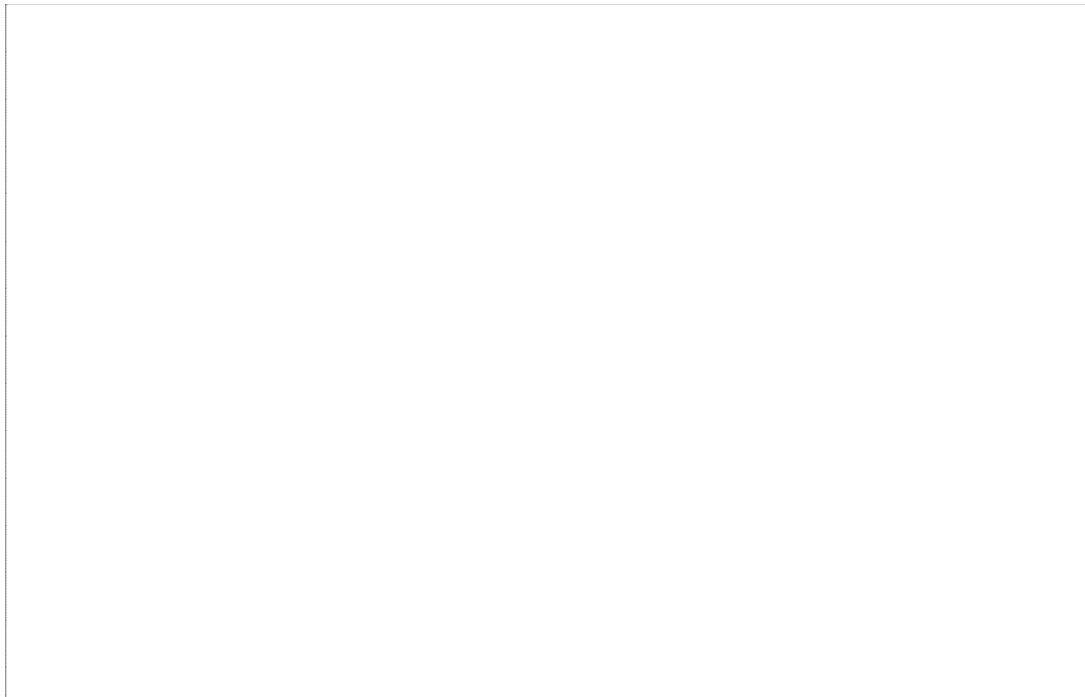
Figure 3.3: 2008 Outpatient Services Utilization Per 100,000 Population



Inpatient Quality Indicator for Cesarean Delivery Rate

Inpatient quality indicator reports are created using Inpatient Quality Indicator (IQI) software developed by the Agency for Health Care Research and Quality and the Department for Health and Human Services. The data used to develop the IQI reports are standardized administrative information routinely submitted by Kentucky hospitals to bill for their services. Reports provide a measure of the quality for specific medical conditions, quality for specific surgical procedures, and utilization of procedures for which there are questions of overuse, underuse or misuse. IQI21 – Cesarean Delivery Rate was examined due to the potential for overuse, underuse, or misuse. The following chart compares the incidence of cesarean delivery by race/ethnicity as compared to the population.

Figure 3.4: Incidence of Cesarean Delivery Rate (IQI 21) by race/ethnicity as compared to Population



Inpatient Hospital Discharges and Utilization of Emergency Department for Specific Conditions

Asthma

Asthma is identified on administrative billing records by a primary ICD-9 diagnosis code of 493.00 through 493.92. During 2008 there were 6,648 inpatient hospital discharges for asthma, which represents 1.13% of all discharges. The following provides a per 100,000 population inpatient hospital discharge for asthma comparison of whites, African Americans, and Hispanics. African American utilize inpatient hospital services for asthma the most at 313 per 100,000 population. Hispanics utilize inpatient hospital services for asthma 81% less often than African American, and whites utilize inpatient hospital services for asthma 55% less often than African American

Figure 3.5: 2008 Inpatient Hospital Discharges for Asthma Per 100,000 Population



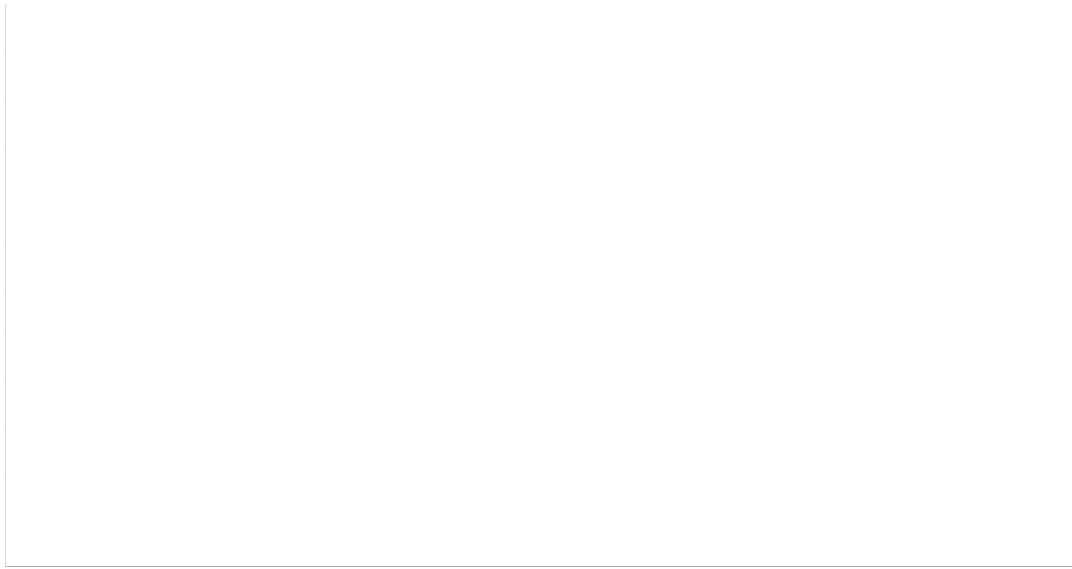
During 2008 there were 17,931 emergency department visits for asthma, which represents 1.09% of all emergency department visits. The following provides a per 100,000 population emergency department utilization for asthma comparison of whites, African Americans, and Hispanics. African Americans utilize emergency department services for asthma the most at 1,253 per 100,000 population. Hispanics utilize emergency department services for asthma 80% less often than African Americans, and whites utilize emergency department services for asthma 73% less often than African American.

Figure 3.6: 2008 Emergency Department Utilization for Asthma Per 100,000 Population



Chronic Obstructive Pulmonary Disease (COPD)

COPD is identified on administrative billing records by a primary ICD-9 diagnosis code of 490 through 492.9 or 494 through 496. During 2008 there were 20,597 inpatient hospital discharges for COPD, which represents 3.5% of all discharges. The following provides a per 100,000 population inpatient hospital discharge for COPD comparison of whites, African Americans, and Hispanics. Whites utilize inpatient hospital services for COPD the most at 498 per 100,000 population. African Americans utilize inpatient hospital services for COPD 55% less often than whites, and Hispanics utilize inpatient hospital services for COPD 94% less often than whites.



During 2008 there were 30,188 emergency department visits for COPD, which represents 1.83% of all emergency department visits. The following provides a per 100,000 population emergency department utilization for COPD comparison of whites, African American, and Hispanics. African Americans utilize emergency department services for COPD the most at 767 per 100,000 population. Hispanics utilize emergency department services for COPD 65% less often than African Americans, and whites utilize emergency department services for COPD 9% less often than African Americans.

Figure 3.7: 2000 Emergency Department Utilization for COPD Per 100,000 Population



Heart Failure

Heart Failure is identified on administrative billing records by a primary ICD-9 diagnosis code of 4280 through 4289. During 2008 there were 16,064 inpatient hospital discharges for Heart Failure, which represents 2.73% of all discharges. The following provides a per 100,000 population inpatient hospital discharge for Heart Failure comparison of whites, African Americans, and Hispanics. African Americans utilize inpatient hospital services for Heart Failure the most at 437 per 100,000 population. Whites utilize inpatient hospital services for Heart Failure 14% less often than African Americans, and Hispanics utilize inpatient hospital services for Heart Failure 92% less often than African Americans.

Figure 3.8: 2008 Inpatient Hospital Discharges for Heart Failure Per 100,000 Population



During 2008 there were only 3,201 emergency department visits for Heart Failure, which represents 0.19% of all emergency department visits. Due to the small numbers utilizing emergency department services for Heart Failure, an analysis by race/ethnicity was not performed.

Limitation

This data only represents data for one year, the first year of data collection. Therefore, specific conclusions cannot be drawn to delineate the causes of racial/ethnic disparities.

PART IV

RECOMMENDATIONS

Policy Recommendations from the Office of Minority Health's 2006 National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health

- Increase education and training opportunities for minority healthcare providers and researchers
- Stabilize the funding for programs supporting minorities (Title VII)
- Increase the amount of minorities in the health professions, including medical, nursing, dental and social work professions [In 2006, African Americans, Latinos and American Indians comprise 25% of the national population, but these groups represent only 9% of the nursing profession and 6% of the medical profession and 5% of dental profession.]
- Implement more evidenced-based health disparity interventions in communities with large populations of racial and ethnic minorities
- Improve the social conditions and environments in which racial and ethnic minorities live
- Promote public policies that truly ensure non-discrimination and privacy—especially concerning translation genomics research, healthcare access and quality issues
- Promote economic development initiatives in under privileged communities
- Increase the number of sustainable communities
- Increase the availability of affordable housing
- Increase educational opportunities for minorities within communities, including better access to post secondary education and the of design programs that decrease the secondary education attrition
- Promote work force development by increasing the representation of minorities in organized labor parties
- Promote policies that target poverty prevention
- Encourage initiatives that increase social capital and resource availability within communities and reduce physical and social barriers to healthy lifestyles, e.g. increase pedestrian friendly design of neighborhoods, access to and subsidization of healthy food options
- Strengthen relationships between state and federal agencies that safeguard minority health
- Develop minority leadership and increase representation in state agencies
- Improve data collection methods and surveillance of health disparities, including methods of data aggregation, analysis and disaggregation, to elucidate the specific parameters of each health or health-related problem.
- Complement demographic and statistical data analysis with research targeting the cultural, sociological and generational implications of health disparities.
- Expand funding for and improve federally funded community health centers
- Build bridges for communication, avenues for interaction and consensus for action among policy makers, researchers, healthcare workers and community leaders.
- Prioritize the elimination of health disparities on the national and state legislative agenda and where appropriate, allocate and sustain the necessary resources for successful program implementation

Executive Orders for Eliminating Health Disparities and Improving the Cultural Competency in the Public and Private Sectors

- **Executive Order No. 13256: President's Board of Advisors on Historically Black Colleges and Universities (February, 2002)**- In order to advance the development of the Nation's full human potential and to advance equal opportunity in higher education, to strengthen the capacity of historically black colleges and universities to provide the highest quality education and to increase opportunities for these institutions to participate in and benefit from Federal programs, as do other colleges and universities; a presidential advisory committee was established in the Office of the Secretary of Education in order to ensure the long-term viability and enhancement of these institutions
- **Executive Order No. 13270: Tribal Colleges and Universities (July, 2002)** - In order to extend the Nation's commitment to education excellence and equal opportunity to the tribal colleges and universities that serve Indian tribes and Alaska Native entities, a board of advisors was established to ensure that this national policy regarding the tribal colleges is carried out with direct accountability at the levels of the Federal Government.
- **Executive Order No. 13171: Hispanic Employment in the Federal Government (October, 2000)** - In order to improve representation of Hispanics in Federal employment, within merit system principles and consistent with the application veteran's preference criteria, to achieve a Federal workforce drawn from all segments of society, additional policies are recommended to eliminate the under representation of Hispanics in the Federal workforce. These include policies that provide a plan for recruitment, eliminate of systemic barriers, ensure selection factors are appropriate, improve outreach, and reflect a continuing priority for eliminating Hispanic under representation in the Federal workforce.
- **Executive Order No. 13166: Improving access to Services for Persons with Limited English Proficiency (August 2000)**- Ensuring individuals with limited proficiency in English (LEP) access to appropriate language assistance services among recipients of federally funded programs and services has been identified as a critical element in healthcare, welfare, transportation and immigration reforms. All entities receiving federal funds, such as schools, local police departments, doctors and hospitals are required to ensure consistent and uniform language assistance, especially among Spanish speaking LEP individuals. Under the Executive Order, "each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons." In addition, "each agency providing Federal assistance [to hospitals, universities or a myriad of other state and other entities] shall draft Title VI guidance."
- **Executive Order No. 13339: Increasing Economic Opportunity and Business Participation of Asian Americans and Pacific Islanders (May, 2004)**-For the purpose of providing equal economic opportunities for full protection of Asian American and Pacific Islanders, a Presidential Advisory Commission on Asian Americans and Pacific Islanders was established in the Department of Commerce. The Commission provides advice to the President on the development, monitoring, and development of Asian American and Pacific Islander businesses as well as ways to increase business diversification and community development.

- **Executive Order No. 13125: Increasing Participation of Asian Americans and Pacific Islanders in Federal Programs (June 2007)**- In order to improve the quality of life of Asian Americans and Pacific Islanders through increased participation in Federal programs where they may be underserved (e.g. health, human services, education, housing, labor, transportation, and economic and community development) the President's Advisory Commission was established in the Department of Health and Human Services. The Commission is charged with advising the President concerning the development, monitoring and coordination of federal efforts to improve the quality of life of Asian Americans and Pacific Islanders.
- **Executive Order No. 13230: President's Advisory Commission on Educational Excellence for Hispanic Americans Proclamation (October, 2001)**- In order to advance the development of human potential, strengthen the Nation's capacity to provide high-quality education, and increase opportunities for Hispanic Americans to participate in and benefit from Federal education programs, a Presidential Advisory Commission on Educational Excellence for Hispanic Americans was established in the Department of Education. The Commission is charged with advising the President on the development, monitoring and coordination of Federal efforts to promote high quality education for Hispanic Americans as well as ways to increase parental, State and local, private sector and community involvement in improving education.

(Centers for Disease Control and Prevention Department of Minority Health, 2009)

Policy Recommendations by the Office of Minority Health (OHM)

- **Office of Management and Budget and the Office of Regulatory Affairs**-Adoption and compliance with directives set forth by the Office of Management and Budget and the Office of Regulatory Affairs' Interagency Committee for the surveillance of minority health. Based on the Interagency Committee's review on racial and ethnic standards, recommendations were provided in a detailed report regarding the classification of federal data on race and ethnicity and the logistics for census data collection, measurements and analysis.
- **Title VI Policy Guidance on the Prohibition Against National Origin Discrimination as It Affects Persons With Limited English Proficiency**- The Office of Civil Rights (OCR) issued internal guidance to its constituents relating to compliance with the law as it applies to US Department of Health and Human Services [HHS] funded programs. Under Title VI of the Civil Rights Act of 1964, hospitals, HMOs, social service agencies and other entities that receive federal financial assistance from the HHS are required to take the steps necessary to ensure that individuals with LEP can meaningfully access the programs and services. This guidance enhances our ability to reach our national goal of eliminating racial and ethnic disparities in health, and will assist in increasing opportunities for persons with LEP to improve their socioeconomic status.

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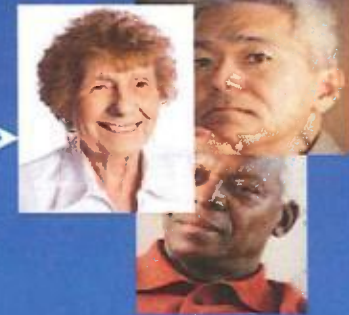


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Hospital discharge data
are already being
collected

Hospital discharge data
can generate valuable
healthcare information

Information can be
used to make decisions

Utilization and
costs of care
in hospitals

Rates of diseases
in particular areas

Quality of care
in hospitals

Rates of procedures
in particular areas

Preventable hospital
stays that indicate
breakdowns in care

Key features of MONAHRQ...

Currently based
on hospital
discharge data



Host user downloads
MONAHRQ software from
AHRQ website



Software



Host user
applies
software to
own data
locally



Host user creates
local website on
their own server

MONAHRQ



Host user makes
website available

- Internally to better understand own data and to answer questions
- To member organizations, e.g., through a password protected site
- Publicly to provide information to the community

The End User Website - Demo



State Healthcare Information Portal

This website provides information on hospitals in for patients, policymakers, and other users of health care information. Choose from the information options below.

- [Home](#)
- [Quality Indicators](#)
- [Maps](#)
- [Rates](#)
- [Utilization Statistics](#)
- [Site Map](#)
- [Definitions](#)
- [AHRQ Website for Quality Indicators](#)
- [Medical Dictionary](#)

Quality Indicators for Hospitals and Geographic Areas

View measures of quality using the AHRQ Quality Indicators - measures of patient safety, mortality, utilization, and volume. Compare results by region or by specific hospitals in an easy-to-use format. Or examine detailed statistics by region and hospital.

View Maps Showing Potentially Avoidable Hospitalizations

Use the AHRQ Preventable Hospitalization Tool to map selected Quality Indicators by county. Estimate the cost savings associated with reducing the level of potentially avoidable hospitalizations. Identify communities for future interventions such as improving preventive and primary care services or improving patient safety.

Rates of Health Conditions and Procedures

View statistics on prevalence of diseases or medical procedures and identify areas with higher rates. View maps of the rates of conditions and procedures by county.

Utilization Statistics for Health Conditions and Procedures

View information about numbers of discharges, charges, costs, length of hospitalization and percent of patients who died in specific hospitals, hospitals in geographic regions, or all hospitals in the in Maryland 17c-3 region. Select patients by medical condition or procedure.

MONAHRQ

Select the information you want:

- **QUALITY INDICATORS**
- **AVOIDABLE HOSPITALIZATIONS**
- **RATES**
- **UTILIZATION**



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Two quality paths to choose from



State Healthcare Information Portal

Your path: Home → Quality Indicators

[Home](#)

[Quality Indicators](#)

[Maps](#)

[Rates](#)

[Utilization Statistics](#)

[Site Map](#)

[Definitions](#)

[AHRQ Website for
Quality Indicators](#)

[Medical Dictionary](#)

MONAHRQ



Would you like to view measures of quality for selected hospitals?

Choose one:

☒ [Information for Consumers](#)

Compare information on hospital quality in an easy-to-use format designed for consumers.

☐ [Detailed Statistics](#)

Conduct a detailed query of information on hospital quality. Related utilization information is also provided.

[<< Back](#)

[Next >>](#)



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Consumer path on Quality Indicators



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State Healthcare Information Portal

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Compare hospital scores

When you are choosing a hospital you should look for the hospital that does **Better than Average** on the topics that are most important to you.

Click on the indicator names to see detailed results on how each hospital performed.

Death rate shows how often patients who were treated for a particular illness or had a particular procedure died while in each hospital during the year.

Rate shows how often a particular procedure was done one way or another. Sometimes rate is out of 100, 1,000, or 10,000 patients.

A hospital's score is calculated in comparison to the National average of hospitals.

- **Average** is about the same as the National average of hospitals.
- **Better than Average** is better than the National average of hospitals.
- **Worse than Average** is worse than the National average of hospitals.

Quality indicator(s) for chosen hospital(s) in 2006

Heart conditions	Hospital 45	Hospital 2	Hospital 40	Hospital 44
Death rate for heart attack patients (Acute myocardial infarction (AMI) mortality rate)	Better than Average	Better than Average	Better than Average	Average
Death rate for patients with congestive heart failure (Congestive heart failure (CHF) mortality rate)	Better than Average	Better than Average	Better than Average	Average
Death rate for patient having a coronary artery bypass graft (CABG) (CABG mortality rate)	Insufficient Data	Average	Insufficient Data	Insufficient Data
Death rate for patient having a percutaneous transluminal coronary angioplasty (PTCA) (PTCA mortality rate)	Average	Insufficient Data	Insufficient Data	Insufficient Data
Rate of cardiac catheterization procedures on both sides of the heart (Bilateral cardiac catheterization rate)	Average	Better than Average	Average	Average

[Home](#) | [Back](#) | [Print Report](#) | [Select Report for Copying](#) | - Use the Edit menu to Copy and Paste to another application.

Arrays information on up to
four hospitals for the
indicators selected.

Click on any indicator and
get detailed information in
graphic form.



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Details in graphic form



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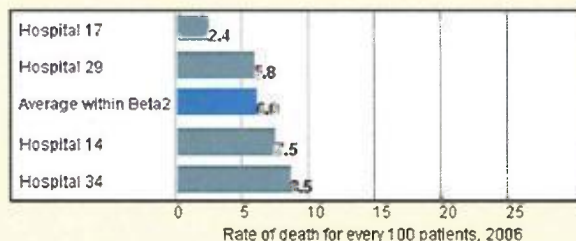
[Home](#) [Back](#) [Print Report](#) [Select Report for Copying](#) - Use the Edit menu to Copy and Paste to another application.

Death rate for heart attack patients

This graph shows how often patients admitted to each hospital after having a heart attack died before leaving the hospital. This information is for patients admitted during 2006.

When you are choosing a hospital you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.

Death rate for heart attack patients



Average: The average rate of deaths of patients who came in after having a heart attack in hospitals within Beta2. This number is included so you have:

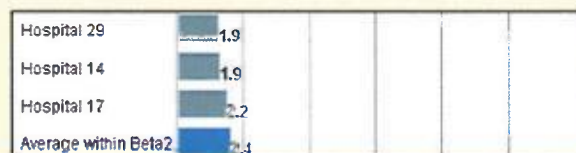
- a better idea of what is typical
- a basis for comparing individual hospitals' performance.

Death rate for patients with congestive heart failure

This graph shows how often patients who were admitted to a hospital because they had heart failure (called *congestive heart failure*) died before leaving the hospital. This information is for patients admitted during 2006.

When choosing a hospital you should look for the hospital that has a **lower** number of deaths for this operation. A **lower** number is shown by a **shorter** bar on the graph below.

Death rate for patients with congestive heart failure



Get details for each hospital
in rank order, compared to
the state average.



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Detailed path on Quality Indicators



State Healthcare Information Portal

Your path: Home → Quality Indicators → Detail Report - Select Region and Health Topic

[Home](#)

[Quality Indicators](#)

[Maps](#)

[Rates](#)

[Utilization Statistics](#)

[Site Map](#)

[Definitions](#)

[AHRQ Website for
Quality Indicators](#)

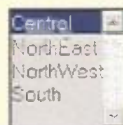
[Medical Dictionary](#)

Select All Hospitals or a Region and then select a Health Topic

The information is organized into topics of health problems and can be summarized for all hospitals or broken down by region.

☒ All Hospitals Grouped Together

☐ Region



☒ Heart conditions

This section includes items such as how many patients died while hospitalized for heart attacks and how often a hospital performs certain heart-related surgeries or procedures.

☐ Childbirth

☐ Hip replacement and hip fracture

☐ Brain and nervous system

☐ Operations for cancer of the esophagus and pancreas

☐ Other health conditions

☐ Other surgeries

☐ Medical complications for patients having an operation

☐ Medical complications for all patients

[<< Back](#)

[View Data Now](#)


☐ View Data in New Browser Window/Tab

The detailed path provides
more information for each
indicator.



Overall results for the state





State Healthcare Information Portal

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Quality Indicator Details for the topic **Heart conditions**

Indicator	Numerator	Denominator	Observed	Expected	Risk-Adjusted	Lower-bound CI	Upper-bound CI
Acute myocardial infarction (AMI) mortality rate	734	10447	0.0703	0.0942	0.0660	0.0614	0.0707
Congestive heart failure (CHF) mortality rate	880	23245	0.0379	0.0663	0.0249	0.0229	0.0269
CABG mortality rate	349	4050	0.0862	0.0553	0.0525	0.0485	0.0565
PTCA mortality rate	251	14654	0.0171	0.0147	0.0152	0.0137	0.0168
Bilateral cardiac catheterization rate	822	22381	0.0367	0.0737	0.0336	0.0306	0.0367

Values based on fewer than 15 discharges

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Information on specific indicators for the entire dataset:

- numerators
- denominators
 - observed, expected and risk-adjusted rates
 - confidence intervals

Click on indicator for hospital-specific information



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HEALTHCARE COST AND UTILIZATION PROJECT

Results by individual hospital



State Healthcare Information Portal

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Quality Indicator Details for the topic **Heart conditions**

IQI15 - Acute myocardial infarction (AMI) mortality rate

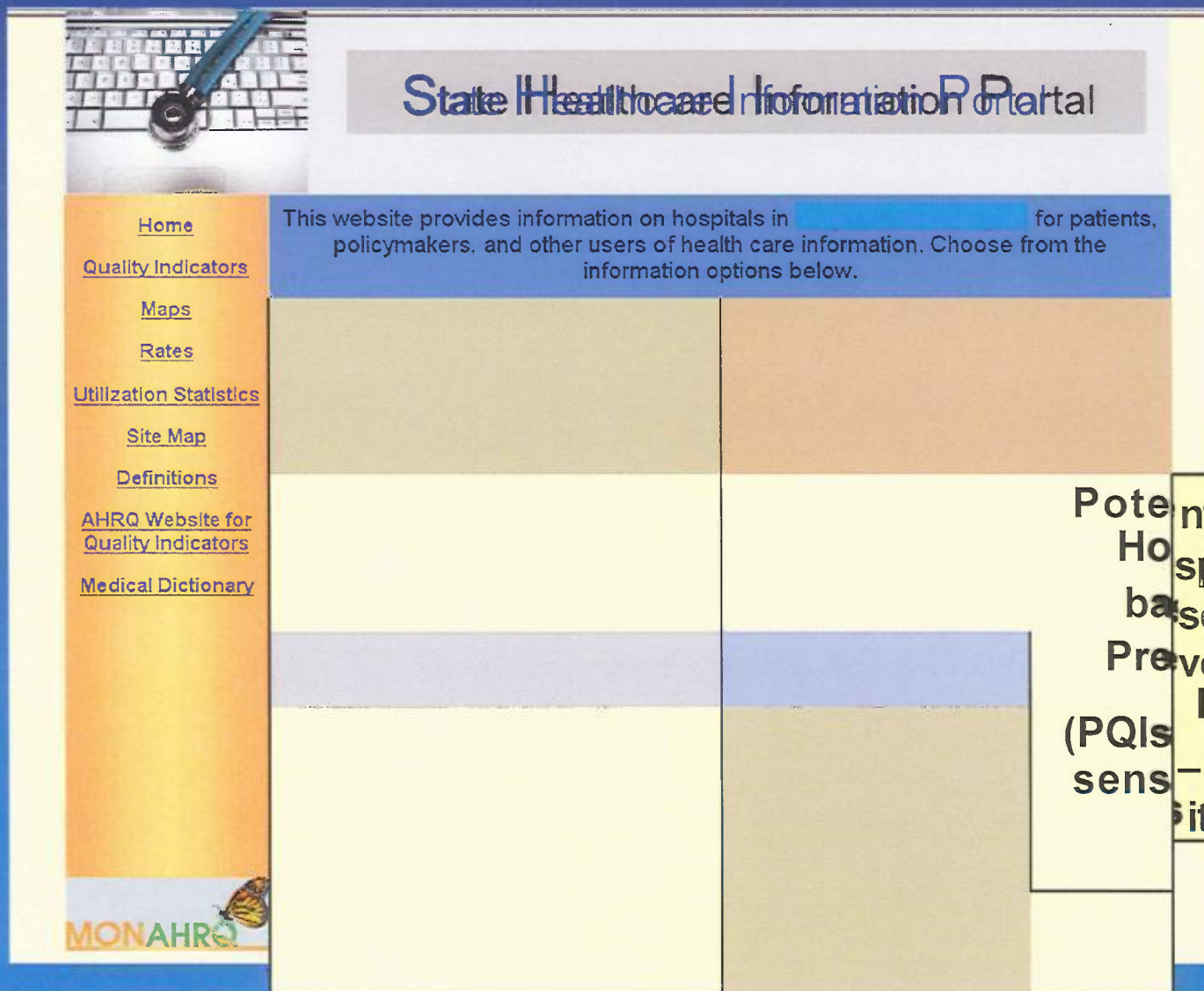
Hospital	Numerator	Denominator	Observed	Expected	Risk-Adjusted	Lower bound CI	Upper bound CI
Hospital 1	52	775	0.0671	0.0734	0.0609	0.0610	0.1007
Hospital 10	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data
Hospital 11	c	c	0.0769	0.1292	0.0527	0.0000	0.1214
Hospital 12	c	c	0.0208	0.0535	0.0345	0.0000	0.1367
Hospital 13	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data
Hospital 14	21	140	0.1500	0.1773	0.0749	0.0468	0.1030
Hospital 15	c	c	0.0567	0.1110	0.0452	0.0074	0.0831
Hospital 16	c	c	0.0000	0.0976	0.0000	0.0000	0.1731
Hospital 17	c	c	0.0310	0.1123			
Hospital 18	c	c	0.0769	0.0937			
Hospital 19	c	c	0.0545	0.1088			
Hospital 2	c	c	0.1111	0.1749			
Hospital 20	c	c	0.0870	0.1948			
Hospital 21	c	c	0.1130	0.1069			
Hospital 22	62	1255	0.0494	0.0557			
Hospital 23	c	c	0.0805	0.1221			
Hospital 24	43	528	0.0814	0.0705			
Hospital 25	c	c	0.1250	0.1226			
Hospital 26	c	c	0.0811	0.1495			
Hospital 27	39	570	0.0684	0.0794			
Hospital 28	c	c	0.0000	0.0612			
Hospital 29	c	c	0.0360	0.1485			
Hospital 3	20	285	0.0699	0.1307			
Hospital 30	c	c	0.0453	0.0913			
Hospital 31	91	785	0.1158	0.0596			
Hospital 32	c	c	0.0397	0.0712			
Hospital 33	c	c	0.0927	0.1132			
Hospital 34	c	c	0.1389	0.1439			
Hospital 35	19	239	0.0795	0.0945			
Hospital 36	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data
Hospital 37	c	c	0.0897	0.1447			
Hospital 38	c	c	0.0563	0.0369			

Information:

• numerator

• denominator

Potentially Avoidable Hospitalizations



The screenshot shows the 'State Healthcare Information Portal' website. At the top, there is a header with the AHRQ logo on the left and the H·CUP logo on the right. The main title 'Potentially Avoidable Hospitalizations' is centered at the top. Below the title, the portal is divided into a grid of colored boxes. On the left side, there is a vertical navigation menu with links: Home, Quality Indicators, Maps, Rates, Utilization Statistics, Site Map, Definitions, AHRQ Website for Quality Indicators, and Medical Dictionary. The main content area contains a large blue box with the text: 'This website provides information on hospitals in [blank] for patients, policymakers, and other users of health care information. Choose from the information options below.' Below this text are several large, empty colored boxes in shades of tan, orange, and blue. At the bottom left of the portal, there is a small logo that says 'MONAHRQ' with a butterfly icon.

Potentially Avoidable
 Hospitalizations –
 based on AHRQ's
 Prevention Quality
 Indicators
 (PQIs – ambulatory care
 sensitive conditions)



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Potentially Avoidable Hospitalization Path Hospitalization Path



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Summary Table and Potential Cost Savings

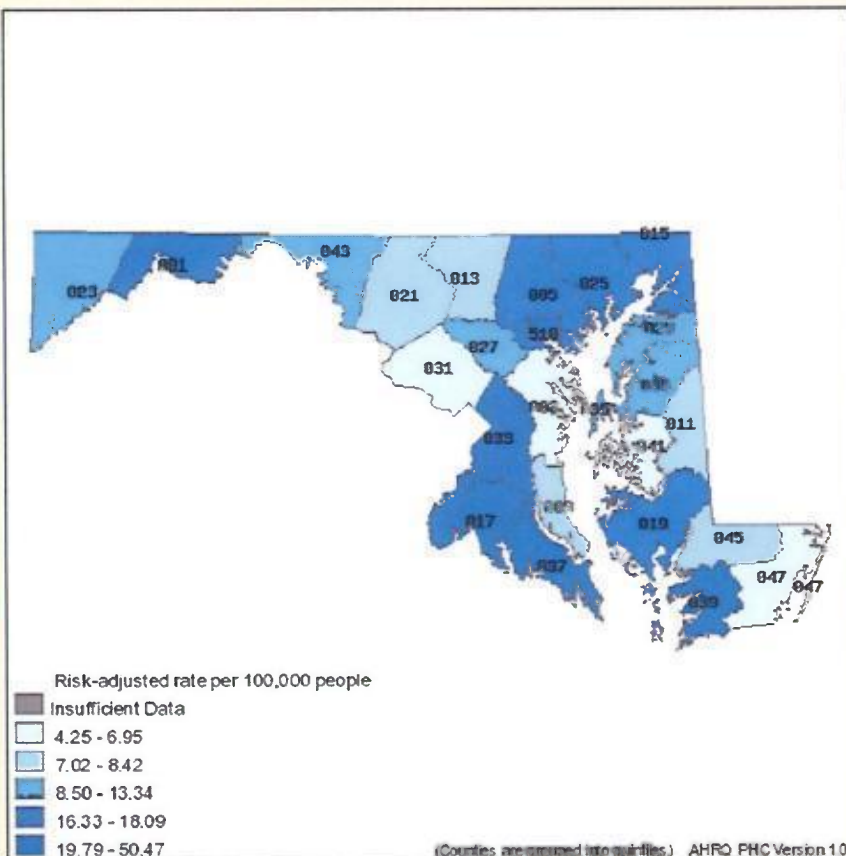
Uncontrolled diabetes admission rate (2006, PQI14)

Maryland

Counties

Code Name

001	Allegany
003	Anne Arundel
005	Baltimore
009	Calvert
011	Caroline
013	Carroll
015	Cecil
017	Charles
019	Dorchester
021	Frederick
023	Garrett
025	Harford
027	Howard
029	Kent
031	Montgomery
033	Prince George's
035	Queen Anne's
037	St. Mary's
039	Somerset
041	Talbot
043	Washington
045	Wicomico
047	Worcester
510	Baltimore City



Rates for avoidable
admissions by county –
Highest rates in dark blue,
lowest rates in light blue

Click on Summary Table
for more details

Home Back Print Report Select Report for Copying Use the Edit menu to Copy and Paste to another application.

Potential cost savings associated with Potentially Avoidable reducing preventable admissions

[Home](#) | [Back](#) | [Print Report](#) | [Select Report for Copying](#) | - Use the Edit menu to Copy and Paste to another application.

Uncontrolled diabetes admission rate (2006, PQI14)

County FIPS Code	Name	Numerator	Denominator	Rates per 100,000			Difference from Overall Risk Adjusted Rate	Cost savings with reduction in the numerator of:				
				Rate	Risk Adjusted Rate	Standardized Rate		10%	20%	30%	40%	50%
24001	MD - Allegany	c	c	18.56	17.17	5.77	lower	3,100	6,200	9,300	12,400	15,500
24003	MD - Anne Arundel	27	386688	6.98	6.95	2.34	lower	10,400	20,900	31,300	41,800	52,200
24005	MD - Baltimore	113	610556	18.51	17.50	1.82	lower	50,500	101,000	151,500	202,100	252,600
24009	MD - Calvert	c	c	7.48	7.71	5.73	lower	2,200	4,300	6,500	8,600	10,800
24011	MD - Caroline	c	c	8.10	7.93	9.19	c	400	800	1,200	1,500	1,900
24013	MD - Carroll	c	c	8.91	8.42	4.04	lower	7,500	15,000	22,500	30,000	37,600
24015	MD - Cecil	c	c	15.86	16.33	5.38	lower	6,100	12,300	18,400	24,500	30,600
24017	MD - Charles	25	103847	24.97	25.88	4.70	higher	10,200	20,400	30,600	40,900	51,100
24019	MD - Dorchester	c	c	20.11	17.91	8.74	higher	2,100	4,300	6,400	8,500	10,700
24021	MD - Frederick	c	c	7.82	8.00	3.62	lower	7,200	14,300	21,500	28,700	35,900
24023	MD - Garrett	c	c	12.90	11.87	9.18	c	1,100	2,100	3,200	4,200	5,300
24025	MD - Harford	33	180971	18.23	18.09	3.42	higher	15,300	30,600	45,900	61,200	76,500
24027	MD - Howard	17	202283	8.48	8.50	3.26	lower	5,500	11,000	16,500	22,000	27,500
24029	MD - Kent	c	c	12.25	11.05	10.85	c	500	900	1,400	1,900	2,300
24031	MD - Montgomery	49	702390	6.98	6.68	1.70	lower	24,700	49,400	74,200	98,900	123,600
24033	MD - Prince George's	128	624881	20.46	21.91	1.91	higher	52,700	105,500	158,200	210,900	263,600
24035	MD - Queen Anne's	c	c	14.05	13.34	7.54	lower	1,500	2,900	4,400	5,900	7,400
24037	MD - St Mary's	25	13874	22.84	26.16	5.55	higher	13,000	26,000	39,100	52,100	65,100
24039	MD - Somerset	c	c	15.90	15.23	3.37	c	2,500	4,900	7,400	9,800	12,300
24041	MD - Talbot	c	c	8.90	8.91	3.31	lower	1,100	2,200	3,300	4,400	5,500
24043	MD - Washington	c	c	8.90	8.73	4.32	lower	4,100	8,200	12,200	16,300	20,400
24045	MD - Wicomico	c	c	8.90	8.91	4.32	lower	1,600	3,100	4,700	6,200	7,800
24047	MD - Worcester	c	c	8.90	8.91	4.32	lower	1,300	2,600	3,900	5,200	6,500
24510	MD - Baltimore City	240	42445	20.45	21.91	1.91	higher	131,600	263,200	394,800	526,400	658,000
TOTAL	Maryland	761	42445	20.45	21.91	1.91		398,700	797,300	1,196,000	1,594,700	1,993,300

Details on avoidable admissions by county, including cost savings.

Can download to Excel.

[View description of data.](#)

[Download data in Microsoft Excel format.](#)

Values based on fewer than 15 discharges are suppressed to protect confidentiality of patients and are designated with a 'c'.

[Home](#) | [Back](#) | [Print Report](#) | [Select Report for Copying](#) | - Use the Edit menu to Copy and Paste to another application.



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Rates of Conditions and Procedures Path



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State Healthcare Information Portal

[Home](#)

[Quality Indicators](#)

[Maps](#)

[Rates](#)

[Utilization Statistics](#)

[Site Map](#)

[Definitions](#)

[AHRQ Website for
Quality Indicators](#)

[Medical Dictionary](#)

This website provides information on hospitals in _____ for patients, policymakers, and other users of health care information. Choose from the information options below.

Rates of health conditions and procedures; –
Use county population as the denominator in prevalence rates

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Groupings of diagnoses and procedures



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HOSPITAL COST AND UTILIZATION PROJECT



State Healthcare Information Portal

Your path: Home → Rates of Health Conditions and Procedures

[Home](#)

[Quality Indicators](#)

[Maps](#)

[Rates](#)

[Utilization Statistics](#)

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[Definitions](#)

[AHRQ Website for
Quality Indicators](#)

[Medical Dictionary](#)

How do you want patients grouped?

There are three ways you can group patients - all patients combined, by MDC/DRG, or by CCS. See below for more information on each option. The [Definitions](#) page provides an explanation of terms used.

☐ [Report by All Patients Combined](#)

Choose this option and click **Next** to select a specific county for detailed reporting.

☐ [Report by the Major Diagnostic Category \(MDC\) / Diagnosis Related Group \(DRG\)](#)

Choose this option and click **Next** to select a specific MDC or DRG for detailed reporting.

To view maps of the rates of specific conditions by county select **All Counties** when choose a geographic region.

Click the link at the top of the table displayed to **View Map of Counties**.

☐ [Report by the Clinical Classification System \(CCS\)](#)

Choose this option and click **Next** to select a specific CCS Diagnosis or Procedure reporting

To view maps of the rates of conditions by county select **All Counties** when asked to choose a geographic region.

Click the link at the top of the table displayed to **View Map of Counties**

[<< Back](#) [Next >>](#)

Can get information on
prevalence of conditions
or procedures by DRG,
MDC, or CCS



Search function



State Healthcare Information Portal

Your path: Home → Rates of Health Conditions and Procedures → CCS

[Home](#)

[Quality Indicators](#)

[Maps](#)

[Rates](#)

[Utilization Statistics](#)

[Site Map](#)

[Definitions](#)

[AHRQ Website for
Quality Indicators](#)

[Medical Dictionary](#)

Choose Clinical Classification System (CCS) Diagnosis or Procedure.

You can view reports for all CCS Diagnoses/Procedures or for a specific CCS Diagnosis/Procedure

- If you would like to view information for a specific county click **Next**.
- If you choose a specific CCS Diagnosis/Procedure **View Data Now** will provide information by demographics (age, gender, and race) summarized across all counties.
- If you choose to view all CCS Diagnoses/Procedures **View Data Now** will provide provide discharge totals summarized across all counties (you may then click on a specific Diagnosis/Procedure to view information by demographics).

The [Definitions](#) page provides an explanation of terms used.

Search chosen list for:

View Information by CCS Principal Diagnosis

- All Diagnoses
- 1 INFECTIOUS AND PARASITIC DISEASE
 - Tuberculosis (TB)
 - Septicemia (blood infection)
 - Bacterial infection
 - Mycoses (fungal and yeast infection)
 - AIDS/HIV infection
 - Hepatitis
 - Viral infection

View Information by CCS Procedure

- Diagnostic dilatation and curettage (D&C)
- Repair of cystocele (bladder hernia) and rectocele (rectal hernia)
- Other diagnostic procedures, female organs
- Other non-operating room therapeutic procedures on female organs
- Other operating room therapeutic procedures on female organs
- 13 OBSTETRICAL PROCEDURES
 - Removal of ectopic pregnancy (abdominal or tubal pregnancy)
 - Episiotomy (incise perineum and vagina to prevent traumatic tearing during delivery)
 - Cesarean section (C-section)

☐ View Data in New Browser Window/Tab

Download detailed data in Microsoft Excel format for [CCS Diagnosis](#) or [CCS Procedure](#).



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Tabular results by county

Home | Back | Print Report | Select Report for Copying | - Use the Edit menu to Copy and Paste to another application

[View Map of Counties \(Principal\)](#)

[View Map of Counties \(All-listed\)](#)

STATISTICS BY COUNTY FOR 134 CESAREAN SECTION (PRCCS 134) WITHIN BETA2, 2006

Hospital County	Number of discharges (all-listed)	Number of discharges (principal)	Rate of discharges per 10,000 persons (all-listed)	Rate of discharges per 10,000 persons (principal)
TOTAL U.S. (standard error)*	1,346,164 (49,097)	1,343,244 (49,073)	45.1	45.0
SOUTH U.S. (standard error)*	535,873 (36,297)	534,925 (36,204)	49.2	49.1
ALL COUNTIES WITHIN BETA2	21,516	21,405	38.3	38.1
MD - Allegany	204	204	20.0	20.0
MD - Anne Arundel	2,295	2,288	45.1	44.9
MD - Baltimore	3,069	3,048	38.9	38.7
MD - Baltimore City	2,838	2,810	45.0	44.5
MD - Calvert	343	343	38.8	38.6
MD - Caroline	85	85	26.1	26.1
MD - Carroll	635	632	37.3	37.1
MD - Cecil	233	231	23.4	23.2
MD - Charles	464	464	33.0	33.0
MD - Dorchester	95	95	30.0	30.0
MD - Frederick	948	947	38.0	38.0
MD - Garrett	40	40	13.4	13.4
MD - Harford	939	939	34.0	34.4
MD - Howard	1,016	1,008	37.3	37.0
MD - Kent	53	53	26.5	26.8
MD - Montgomery	3,695	3,692	39.6	39.6
MD - Prince George's	2,869	2,868	34.1	34.1
MD - Queen Anne's	157	157	34.0	34.0
MD - Somerset	37	37	23.8	23.8
MD - St. Mary's	429	426	43.4	43.1
MD - Talbot	86	86	23.8	23.8
MD - Washington	519	498	36.1	34.1
MD - Wicomico	463	463	50.3	50.3
MD - Worcester	158	158	32.3	32.3
Mission County	1,175	1,180	e	e

For all counties in the state: numbers of discharges and rate per 1,000 population.

Click on Map to view graphic display.



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Map of rates by county

[Home](#) [Back](#) [Print Report](#) [Select Report for Copying](#) - Use the Edit menu to Copy and Paste to another application.

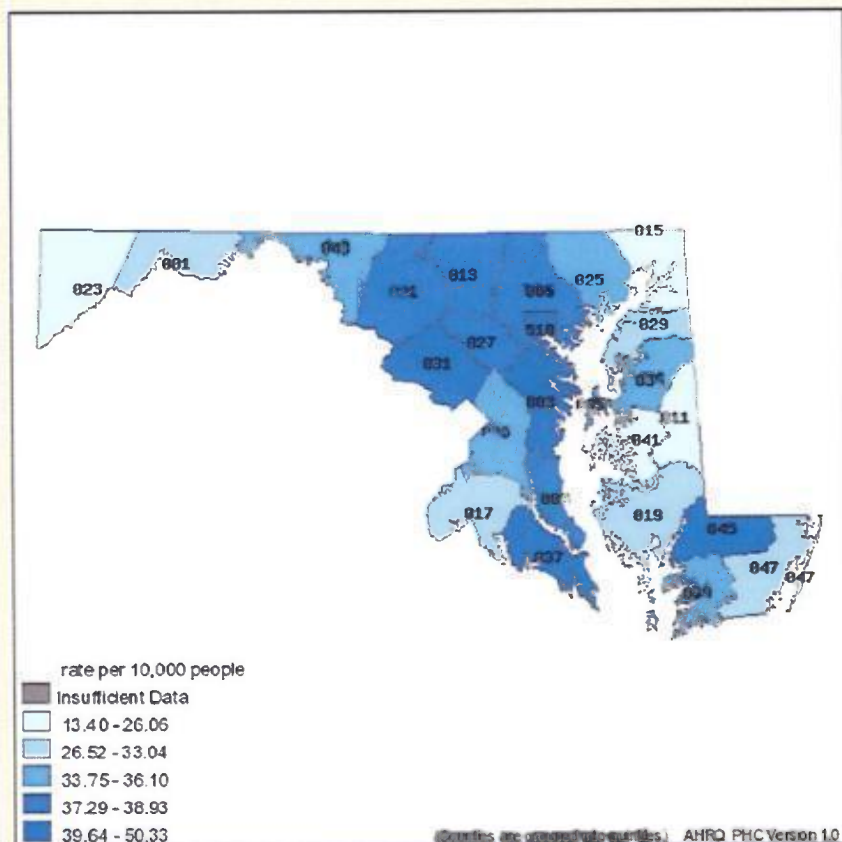
Rates by County for Cesarean section (PRCCS 134)
All-listed Procedures

Maryland

Counties

Code Name

001	Allegany
003	Anne Arundel
005	Baltimore
009	Calvert
011	Carroll
013	Cecil
015	Cecil
017	Charles
019	Dorchester
021	Frederick
023	Gaithersburg
025	Harford
027	Hawkins
029	Kent
031	Montgomery
033	Prince George's
035	Queen Anne's
037	St. Mary's
039	Somerset
041	Talbot
043	Washington
045	Wicomico
047	Worcester
510	Baltimore City



Rates for specific
conditions and
procedures by county –
Highest rates in dark blue,
lowest rates in light blue

[Home](#) [Back](#) [Print Report](#) [Select Report for Copying](#) - Use the Edit menu to Copy and Paste to another application.



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Utilization path



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HEALTHCARE COST AND UTILIZATION PROJECT

The screenshot shows the 'State Healthcare Information Portal' website. At the top, there is a header with the title 'State Healthcare Information Portal' and a sub-header 'This website provides information on hospitals in [redacted] for patients, policymakers, and other users of health care information. Choose from the information options below.' Below the header is a navigation menu on the left with links: Home, Quality Indicators, Maps, Rates, Utilization Statistics, Site Map, Definitions, AHRQ Website for Quality Indicators, and Medical Dictionary. The main content area is divided into several sections, including a large yellow box for 'Utilization Statistics' and a smaller blue box for 'Maps'. The bottom of the page features the AHRQ logo and a butterfly graphic.

State Healthcare Information Portal

This website provides information on hospitals in [redacted] for patients, policymakers, and other users of health care information. Choose from the information options below.

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Utilization statistics
(similar to information from HCU Pnet)



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Utilization across all conditions, entire state



H·CUP
HOSPITAL CARE COST AND UTILIZATION PROJECT

[Home](#) | [Back](#) | [Print Report](#) | [Select Report for Copying](#) | - Use the Edit menu to Copy and Paste to another application.

STATISTICS FOR ALL HOSPITALS COMBINED IN WITHIN BETA2 BY CCS DIAGNOSIS IN 2006

Click on any column header to re-sort the table by that outcome or characteristic.

CCS Diagnosis			Mean charges in dollars	Mean length of stay in days	Percent Died
TOTAL U.S. (standard error)*			\$23,958 (\$495)	4.6 (0.03)	2.0% (0.03%)
U.S. (standard error)*			\$21,893 (\$586)	4.6 (0.05)	2.1% (0.06%)
Conditions			\$10,290	4.2	2.7%
Liveborn	70,761	70,724	\$4,048	3.6	0.4%
Coronary atherosclerosis	142,216	22,065	\$13,317	2.7	1.1%
Nonspecific chest pain	37,376	21,911	\$4,039	1.4	0.2%
Congestive heart failure, nonhypertensive	92,223	21,440	\$12,255	5.0	3.9%
Mood disorders					

for entire database,
discharges

listed by

any column header to re-sort

by:

died or
• condition/procedure

All conditions



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Utilization on individual conditions...



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State Healthcare Information Portal

Your path: Home → Utilization → CCS

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Choose Clinical Classification System (CCS) Diagnosis or Procedure.

You can view reports for all CCS Diagnoses/Procedures or for a specific CCS Diagnosis/Procedure.

- If you would like to view information for a specific hospital or region click **Next**.
- If you choose a specific CCS Diagnosis/Procedure, **View Data Now** will provide information by demographics (age, gender, and race) summarized across all hospitals.
- If you choose to view all CCS Diagnoses/Procedures, **View Data Now** will provide discharge totals summarized across all hospitals (you may then click on a specific Diagnosis/Procedure to view information by demographics).

The [Definitions](#) page provides an explanation of terms used.

Search chosen list for: [Find Next](#) [Find from Top](#)

View Information by CCS Principal Diagnosis

-All Diagnoses-
1 INFECTIOUS AND PARASITIC DISEASE
Tuberculosis (TB)
Septicemia (blood infection)
Bacterial infection
Mycoses (fungal and yeast infection)
AIDS/HIV infection
Hepatitis
Viral infection

View Information by CCS Procedure

-All Procedures-
1 OPERATIONS ON THE NERVOUS SYSTEM
Incision and excision of central nervous system (brain and spinal cord)
Creation of extracranial ventricular shunt (passage to release spinal fluid)
Laminectomy, excision intervertebral disc (back surgery)
Diagnostic spinal tap
Insertion of catheter or spinal stimulator and injection into spinal canal
Decompression (removing pressure from) peripheral nerve
Other diagnostic nervous system procedures

[<< Back](#) [View Data Now](#) [Next >>](#)

☐ View Data in New Browser Window/Tab

Can also search for
utilization information on
individual conditions



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... for individual hospitals

Your path: Home → Utilization → Medical Condition CCS DX 002 → Hospital or Region

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How do you want hospitals grouped?

You can view information for all hospitals combined, for a specific hospital, or for a region.

If you chose a specific condition or procedure the report will provide information by demographics (age, gender, and race).

If you chose to view all conditions or procedures then the report will provide discharge totals for each condition or procedure (you may then click on a specific condition or procedure to view information by demographics).

The [Definitions](#) page provides an explanation of terms used.

☐ View Information for All Hospitals Combined

☒ View Information by Hospital

Hospital 26
Hospital 38
Hospital 46
Hospital 18
Hospital 9

☐ View Information by Region

Central
NorthEast
NorthWest

[<< Back](#) | [View Data Now](#)

☐ View Data in New Browser Window/Tab





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Detailed utilization for all hospitals

STATISTICS BY HOSPITAL FOR 2 SEPTICEMIA (EXCEPT IN LABOR) (DXCCS 2) WITHIN BETA2, 2006

Hospital Name	Hospital County	Number of discharges (all-listed)	Number of discharges (principal)	Mean charges in dollars	Mean length of stay in days	Percent Died
TOTAL U.S. (standard error)*	--	1,256,853 (30,227)	611,422 (18,604)	\$49,525 (\$1,146)	8.9 (0.11)	17.9% (0.29%)
SOUTH U.S. (standard error)*	--	515,784 (21,464)	249,537 (12,235)	\$42,895 (\$1,394)	8.9 (0.16)	17.5% (0.37%)
ALL HOSPITALS WITHIN BETA2	--	35,727	16,258	\$18,545	8.2	17.5%
Hospital 1	MD - Wicomico	1,158	633	\$14,839	8.5	12.0%
Hospital 10	MD - Wicomico	15	c	c	c	c
Hospital 11	MD - Baltimore	976	456	\$23,615	9.9	
Hospital 12	MD - Kent	170	103	\$12,534	8.1	
Hospital 13	MD - Baltimore	c	c	c	c	
Hospital 14	MD - Baltimore	1,263	603	\$21,313	10.8	
Hospital 15	MD - Montgomery	733	486	\$12,744	6.4	
Hospital 16	MD - Somerset	20	c	c	c	
Hospital 17	MD - Montgomery	827	432	\$16,403	7.8	
Hospital 18	MD - Prince George's	1,159	573	\$16,824	8.0	
Hospital 19	MD - Anne Arundel	536	224	\$24,316	10.3	
Hospital 2	MD - Baltimore	827	378	\$16,700	7.7	
Hospital 20	MD - Baltimore	415	154	\$22,006	8.8	
Hospital 21	MD - Garrett	55	72	\$3,555	5.3	
Hospital 22	MD - Baltimore	944	459	\$15,606	7.9	
Hospital 23	MD - Harford	314	198	\$15,729	6.9	
Hospital 24	MD - Baltimore	1,656	326	\$31,134	9.6	
Hospital 25	MD - Prince George's	116	72	\$14,165	8.6	
Hospital 26	MD - Charles	456	180	\$15,443	8.5	
Hospital 27	MD - Baltimore	1,826	356	\$39,224	10.2	
Hospital 28	MD - Baltimore	138	c	c	c	
Hospital 29	MD - Dorchester	172	72	\$10,535	5.2	34.7%
Hospital 3	MD - Baltimore	1,235	619	\$22,365	9.2	20.0%
Hospital 30	MD - Prince George's	836	300	\$16,207	8.5	24.3%
Hospital 31	MD - Baltimore	750	330	\$22,553	8.4	20.1%

Information on:

- numbers of discharges,
 - charges,
 - costs,
 - length of stay,
 - percent died
- for all hospitals individually.

National, regional, and state benchmarks included.



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More details for individual hospitals



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Home Back Print Report Select Report for Copying - Use the Edit menu to Copy and Paste to another application.

STATISTICS FOR HOSPITAL 1 FOR SEPTICEMIA (EXCEPT IN LABOR) (DXCCS 2) WITHIN BETA2, 2006

	Number of discharges (all-listed)	Number of discharges (principal)	Mean charges in dollars	Mean length of stay in days	Percent Died
TOTAL U.S. (standard error)*	1,256,853 (30,227)	611,422 (18,604)	\$49,525 (\$1,146)	8.9 (0.11)	17.9% (0.29%)
SOUTH U.S. (standard error)*	515,784 (21,464)	249,537 (12,235)	\$42,895 (\$1,394)	8.9 (0.16)	17.5% (0.37%)
Total	1,158	633	\$14,839	8.5	12.0%
Age group					
<18	24	c	c	c	c
18-44	116	48	\$11,731	6.8	4.2%
45-64	322	166	\$16,852	9.3	7.8%
65+	696	405	\$14,644	8.4	15.1%
Gender					
Male	526	278	\$14,987	8.4	11.5%
Female	632	355	\$14,724	8.5	12.4%
Payer					
Medicare	c	c	c	c	c
Medicaid	48	19	\$9,898	5.7	5.3%
Private including HMO	73	35	\$17,822	10.3	11.4%
Missing	1,035	578	\$14,824	8.5	12.3%
Race					
White	786	435	\$14,931	8.5	11.7%
Black	341	181	\$15,130	8.7	11.6%
Native American	c	c	c	c	c
Other	30	17	\$9,409	5.7	23.5%

The same information is available for individual hospitals, by

- age group
- gender
- payer
- race

Values based on fewer than 15 discharges are suppressed to protect confidentiality of patients and are designated with a "c".

*Weighted national estimates from HCUP Nationwide Inpatient Sample (NIS), 2006, Agency for Healthcare Research and Quality (AHRQ), based on data collected by individual States and provided to AHRQ by the States. Total number of weighted discharges in the U.S. based on HCUP NIS = 39,450,216. Statistics based on estimates with a relative standard error (standard error / weighted estimate) greater than 0.30 or with standard error = 0 are not reliable, and are designated with a †.



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How do you get there?



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MONAHRQ

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AHRQ
Agency for Healthcare Research and Quality

MONAHRQ

Version: Beta 0.17d - 07/06/2009

View Session Log Save Session Log

Welcome to MONAHRQ - Input your data. Output your website.

Developed by the Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services (DHHS).

MONAHRQ is a free MS Windows-based application that enables you to create a website that displays information on the health care rates and utilization, cost, and quality for hospitals. The final website will be an interactive querying tool that users can navigate to learn about hospital care. Any organization with hospital administrative (discharge) data can use MONAHRQ.

MONAHRQ allows you to import hospital discharge data into a database, create health care metrics, and report results. Four main types of results will be created with information on:

1. Quality of care in hospitals
2. Information on medical conditions and procedures in hospitals
3. Rates of medical conditions and procedures in selected geographic areas
4. Geographic mapping of medical conditions and procedures.

This tool is flexible and will allow you to select what type of information you want to present. You can also choose how to use the final results - as a series of reports or a set of web (HTML) pages. A complete website can be built using this tool that can then be published on a workgroup server or on the web. If you are not interested in hosting a website, the reports can still be disseminated to provide valuable information on hospital care in your area.

MONAHRQ will guide you through a step-by-step process of importing data, creating reports and, if you choose, a comprehensive website. The five basic steps include:

1. Selecting and importing your input data file
2. Defining your hospital groupings
3. Generating your analyses



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Build your website



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MONAHRQ

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Agency for Healthcare Research and Quality



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The final product

State Healthcare Information Portal

This website provides information on hospitals in [blank] for patients, policymakers, and other users of health care information. Choose from the information options below.

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Quality Indicators for Hospitals and Geographic Areas

View measures of quality using the AHRQ Quality Indicators - measures of patient safety, mortality, utilization, and volume. Compare results by region or by specific hospitals in an easy-to-use format. Or examine detailed statistics by region and hospital.

View Maps Showing Potentially Avoidable Hospitalizations

Use the AHRQ Preventable Hospitalization Tool to map selected Quality Indicators by county. Estimate the cost savings associated with reducing the level of potentially avoidable hospitalizations. Identify communities for future interventions such as improving preventive and primary care services or improving patient safety.

Rates of Health Conditions and Procedures

View statistics on prevalence of diseases or medical procedures and identify areas with higher rates. View maps of the rates of conditions and procedures by county.

Utilization Statistics for Health Conditions and Procedures

View information about numbers of discharges, charges, costs, length of hospitalization and percent of patients who died in specific hospitals, hospitals in geographic regions, or all hospitals in the in Maryland 17c-3 region. Select patients by medical condition or procedure.

MONAHRQ



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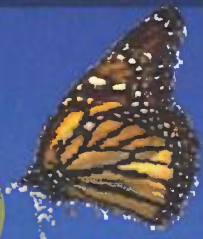


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What makes MONAHRQ unique?

Empowers organizations
and consumers to use data
to make informed decisions

MONAHRQ



- ✓ Organizations create and host their own website and upload their own data
- ✓ Local organizations do quality reporting using a standard, validated method
- ✓ End users draw together multiple data sources providing information at the local level

To get on the mailing list: monahrq@ahrq.gov